EVALUATION OF THE SOUL CITY ADULT EDUCATION TRAINING PROGRAMME IN HIV/AIDS.

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DECLARATION

I, Nisha Naicker declare that this research report is my own work. It is being submitted for the degree of Master of Medicine in the branch of Public Health Medicine in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other University.

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15/09/2006

EXECUTIVE SUMMARY

Introduction

Soul City is a non-governmental organisation that runs a HIV/AIDS Adult Education Training Programme. The training involves fourteen partner organisations. The training programme uses the Soul City HIV/AIDS materials to train master trainers, who then train others (community trainees) to use the materials (A cascade model of training).

Objectives of the study

The study evaluated whether the training programme has met its objectives, the effectiveness of the training cascade model and the impact of the training,

Methodology

Study design: The study was divided into 2 sub – studies. The respondents were randomly and proportionately selected per province. Questionnaires were developed and the participants were interviewed telephonically or face to face.

Study Period: July- August 2004.

Study population: 1. Partner organisations managers and master trainers. Sample size of 30.

2. Community trainees. Sample size of 265.

Results

Master trainers: Impact of the training on the organisations and individuals was positive, since it strengthened the organisations and improved knowledge and attitudes of participants.

A few, mainly administrative problems were experienced by the partner organisations, however these problems were subsequently dealt with.

Community Trainees: A large number of community trainees are being trained and they are training others in the community. The majority of the training took place in urban areas. Reaching rural areas was a challenge. 83% of participants had a very good knowledge and understanding of HIV/AIDS related issues. Participants scored highly on assessment of their behaviour as well. The majority of trainees had positive views of the training.

Conclusion

The study showed that the training programme had met its objectives and the cascade training model used was effective. Thus the training process was effective in training individuals and contributing to positive changes in the partner organisations and on an individual level.

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ABBREVIATIONS AND DEFINITIONS

1. **MT – Master trainers** Trainers from the partner organisations that are taught at Soul city. They then go out and train other community trainees (NGO's, CBO's and people in the community).
2. **CT- Community trainees** Taught by the master trainers from the partner NGO's. They in turn train people in their community.
3. **AIDS** Acquired Immune Deficiency Syndrome
4. **HIV** Human immunodeficiency virus
5. **NGO** Non Governmental Organisation
6. **CBO** Community Based Organization
7. **SANAC** South African National Aids Council
8. **NACOSA** National AIDS Coordinating Committee of South Africa
9. **CASE** The Community Agency for Social Enquiry
10. **UNAIDS** United Nations AIDS Organisation
11. **EC** Eastern Cape Province
12. **FS** Free State Province
13. **G** Gauteng Province

14. **KZN** Kwa- Zulu Natal Province
15. **L** Limpopo Province
16. **M** Mapumalanga Province
17. **NP** Northern Province
18. **N.W** North West Province
19. **WC** Western Cape Province

20. **Areas where the training took place**:

"Urban formal settlements (UF): This is a structured and organized area. A local council or district council controls development in these areas Services such as water, electricity and refuse removal are provided, roads are formally planned and maintained by the council. This category included suburbs and townships.

Urban informal settlements (UI): These are also called squatter camps and occur on land, which has not been surveyed or proclaimed as residential. The dwellings are informal. They are usually found on the outskirts of towns or in pockets inside towns or along roads and railways.

Rural (R): These areas include farms and tribal villages. Villages have pockets of houses or huts clustered throughout the area with large areas of grassland and/or fields in between."[29, 28]

21. **Edutainment Approach:** The use of different educational tools such as a mixture of television, radio and print materials to educate the public about numerous issues while entertaining them.

1.0 INTRODUCTION

1.1 HIV/AIDS and intervention strategies in South Africa

HIV/AIDS is a global problem. The rates of infection are still increasing in many countries around the world, especially in Sub Saharan Africa. In 2003 an estimated three million people in the Sub-Saharan region became newly affected.[1]

The 2001 National HIV and syphilis antenatal sero-prevalence survey in South Africa showed that 24.8% of pregnant women were infected with HIV, indicating that 4.74 million South Africans were probably infected with the virus, of whom 189 000 were babies.[4] The October 2002 antenatal survey showed that 26.5% of pregnant women were HIV positive.[5] The 2004 National HIV and syphilis antenatal sero-prevalence survey indicated that the prevalence rate was 29.5% compared to 27.9% in 2003.[35] This 2004 survey showed that the Eastern Cape, KwaZulu Natal and Limpopo had significant increases in the prevalence rates of HIV. The HIV prevalence of the general population was extrapolated from the survey data and it showed that 5.7 million to 6.7 million people may be HIV positive in South Africa. Thus HIV continues to be a major problem.

There are a number of initiatives aimed at curbing the epidemic in South Africa. These were implemented by the government via the public health sector or by Non Governmental Organisation's (NGO'S) or Community Based Organisation's (CBO'S). The government first established its AIDS Advisory Group in 1985. In 1992 the National AIDS Coordinating Committee of South Africa (NACOSA) was established to draft a National AIDS Strategy. In 1994 a "National AIDS Plan" was developed but not fully implemented. After this the

government's HIV education campaign, the 'Beyond Awareness' campaign was started; this ran from 1998-2000. It was a national mass multi media campaign that was targeted mainly at young people. It also promoted a free National AIDS helpline that commenced in 1992.[21]

In February 2000 the South African National AIDS Council (SANAC) was launched. The SANAC is made up of representatives in the government, business, civil society and the medical sector.[3] SANAC then developed the HIV/AIDS Strategic plan for 2000 to 2005. The purpose of the strategic plan was to "guide the country's response as a whole to maximize efficiency and effectiveness."[2] The goals were to reduce the number of new infections and to reduce the impact on individuals, families, communities and businesses.

There has also been a significant response from Non Governmental Organisation's (NGO's) in South Africa in terms of education and training of professionals and lay people, as well as providing support for communities and individuals affected by HIV in the form of home-based care initiatives. A comprehensive network of organisations dealing with issues around HIV/AIDS exists around South Africa.[3] The response from NGO's has been better in the more urban areas around South Africa. Partnerships between NGO'S or with the government assist in combining resources to contribute to the national HIV/AIDS prevention campaign.[6]

The Soul City Institute for Health and Development Communication (IHDC) is a South African NGO that was established in 1992. It was designed to educate and empower people to make better choices about their health. The Soul City Series is made up of:

- A prime time television series,
- A daily radio drama,

• Three booklets on the health topics covered in the broadcast media,

• A publicity campaign which keeps people talking and thinking about Soul City,

• Adult education and youth life skills materials.

These multimedia communication vehicles enabled Soul City to deal with a range of health and development issues over time. Thus Soul City has used edutainment (defined on page x) since 1994 with seven series of Soul City TV, two series of Soul Buddyz TV series which was first developed in 1998 for children, seven series of Soul City Radio in nine languages, fifteen information booklets (one million copies of each) and life skills packs for grades 7, 8 and 9. Many of the information booklets deal with the various aspects of the HIV/AIDS epidemic. Soul City is also used in eleven other African countries and in Romania, Surinam and Papua New Guinea. [23]

In 1999, an educational campaign called 'Lovelife' was started. The Lovelife programme aimed to delay first sexual intercourse, reduce the number of partners and to encourage young people to have safe sex.[21,22]

The government also launched a campaign in 2001 to educate people about HIV/AIDS. This campaign called “Khomanani”, was run by a consortium of organisations including Soul City.[21]

All these initiatives have aimed to decrease the spread of HIV/AIDS with varying degrees of success.

1.2 Behaviour and Social Change Theory

In South Africa there are many factors that exacerbate the epidemic including high-risk behaviours, socio-economic factors, illiteracy, a lack of formal education, stigma and discrimination due to incorrect information about HIV/AIDS.[2 3]

Behaviour and social change are thus essential factors in the control of the HIV epidemic. In most countries the epidemic is driven by behaviours and social conditions that determine the risk of infection. However changing the high-risk behaviour patterns associated with the HIV spread is not an easy task. Focusing only on risky behaviours of individuals is insufficient if one does not also consider the social determinants that aid in the spread of the epidemic. Thus behaviour change depends on social change.[10] There is a shift away from focusing mainly on individual behaviour to a more social approach to changing behaviour. Effective and positive responses to behaviour change in the HIV /AIDS context is dependent on several factors that don't only involve the individual. [11] These include compliance of more than one person such as condom use and the dependence on the availability of services such as voluntary testing and counseling. A change in behaviour to prevent HIV doesn't result in anything i.e. there is no visible change to the individuals health, thus the motivation to sustain the change is sometimes low. [11] This illustrates the need for a more social approach.

Health promotion models also focuses on factors within and outside of an individual's control in order to have a positive impact on health and social outcomes.[12]

Behaviour change theory suggests that "environmental forces beyond the control of individuals impact positively or negatively on the behaviour change process". [13] Thus

community/societal level models that focus on change in societal structures and processes are supportive of healthy lifestyles to complement individual education.[13,14]

The Diffusion of Ideas Model [7, 13,15] describes the process of behaviour change on a macro level (in communities and society) as an s- shaped curve: initially, adoption of a particular behaviour is slow. This is followed by the majority rapidly accepting the behaviour, and then slower acceptance of the behaviour by the minority. Tapping into social networks and working with community role models and early adopters can hasten this process. Different networks can be used depending on the subject of the health promotion material. [7]

Social influence theories state that perceptions and behaviours of peers or groups to which one belongs to, influences one's perception and behaviour.[12] Many studies or programmes have also used the principles of Bandura's "social learning theory or social cognitive theory".[7] This is a model of self directed behaviour change that states that an individual "is able to self regulate behaviour and to participate actively in the learning and application of behaviour change skills". [7] The value of this model is the assumption that with active learning or practice of a new skill the change in behaviour is more sustainable.

Public debate and dialogue are also important areas that can lead to social influence.[13]

Soul City uses a model of social change that integrates existing models of social and behaviour change. Included in Soul City's model are the principles of the Ottawa Charter on Health Promotion.[13]

Behaviour modification has succeeded in certain HIV/AIDS prevention programmes. The San Francisco AIDS education programme, 1984-1987, was a campaign that used aspects of a pan-theoretical model of social influence to bring about behaviour change.[16]The 4 social influences- education, persuasion, motivation and facilitation were used to varying degrees and this lead to positive results.[16] In Africa, Uganda has shown a decrease in HIV prevalence from 21.1% to 9.8% from 1991-98. This further decreased to 6.4% in 2001 among pregnant women attending the antenatal clinics. These results are due to change in population behaviours such as a decrease in non-regular partners by 65%, a decrease in overall sexual activity and increased condom use, and improved communication and education.[17] In Uganda the drop in HIV prevalence was not due to mass media health promotion campaigns. Low-beer and Stoneburner attributed the behaviour change to more personal communication.[17] This means that educating small groups or individuals and people discussing their own experiences resulted in a more effective change.

Thus high-risk behaviour modification is definitely possible with the distribution of accurate information and empowering the individual and communities.

1.3 Soul City Adult Education Training in HIV/AIDS

The Soul City Institute for Health and Development Communication (IHDC) focuses on social change using different educational tools to bring about positive social change relating to a number of issues. Communication with large numbers of people (communities) in order to transmit knowledge and influence behaviour is an important public health tool.[7] The aim is to improve the quality of life through social change. Soul City uses edutainment to educate the public about HIV/AIDS and disseminates these messages throughout South Africa. This is illustrated in Figure 1.1. The behaviour change concept used is one of "positive, pro-social role modeling" [13] and also shows the audience alternative ways of handling difficult situations and coping strategies. This is done in a way that promotes self-identification and self-reflection and leaves the audience with the knowledge of having choices in bringing about change in their lives. [13]

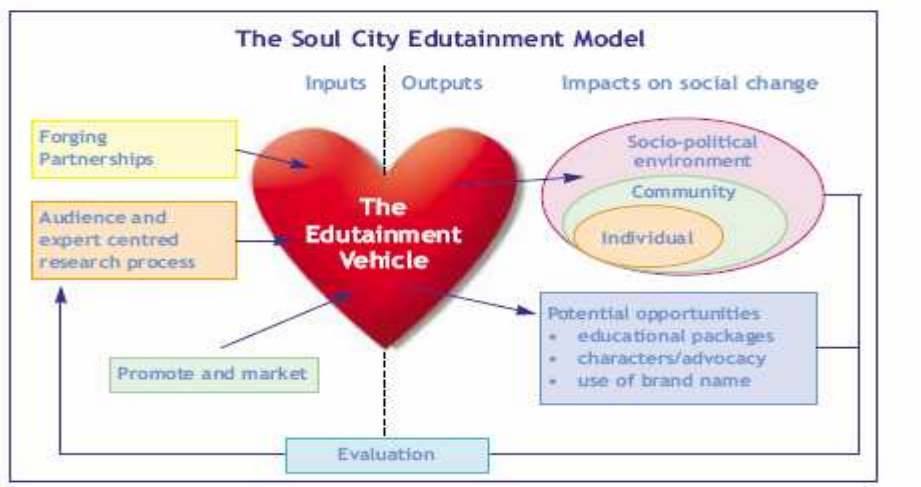

Figure 1.1 The Soul City Edutainment Model (Taken from Evaluation of Soul City Series 5).[24]

The education materials are based on the Soul City television and radio stories. They therefore attract the trainee, who may already be familiar with the Soul City stories and characters. This aims to encourage the trainee to use the materials, and learn more about the health and development issues raised in the mass-media. [23] The Soul City Series 4 Evaluation showed that more than 16.2 million youth and adults were reached through its television and radio shows. Men and women received equal exposure.[25]

Soul City has established a training programme to accompany these materials that enables people to learn about the AIDS epidemic in an interactive environment. The Soul City IHDC educational materials were carefully researched and assessed by experts in the topic fields, as well as tested with the target audience. The materials were evaluated by The Community Agency for Social Enquiry and the Womens Health Project in 2000. Both of these independent evaluators found the material to be of good quality and recommended training of the users. [8]

The Soul City Adult Education Training Programme occurs throughout South Africa, both in urban and rural areas. This programme has reached many people either through a formal training process or informally through communication within communities.[*]

1.3.1 The Soul City training process:

Soul City worked with 14 partner NGO's to do the training. The NGO's were selected through an open process involving advertising in newspapers. This was followed by an interview selection process. All the NGO's that were selected already had some experience in

[*] Personal communication with the Soul City training department.

training and teaching about HIV/AIDS generally and they also had a contextual understanding of HIV/AIDS issues locally. Training was thus tailored to meet the needs and situations of the target group of the population. These NGO's sent master trainers (MT) from their organisations to Soul City to learn how to train using the Soul City materials. The master training was conducted over a 3-day period. The master trainers (MT) then went on to run training workshops and train people-community trainees- in other organisations and communities. The community trainees (CT) that are produced could then get the Soul City materials for free and go on to educate people in their communities (A cascade pattern of training). This is illustrated in Figure 1.2.

Figure 1.2 Cascade training model

The Soul City materials looked at different issues around HIV & AIDS. The materials pack consisted of:

- Two comics – *George's story and Simanga's choice*- these aim to educate while entertaining. They follow the television story and deal with a number of issues in an entertaining way. The comics are available in four languages.
- A set of HIV and AIDS Posters – Eight posters used characters from the Soul City television series to illustrate important messages about HIV/AIDS. These were especially important when working with people with low levels of literacy. They were designed to be used in facilitated discussion forums and information on how to use them and the key messages are detailed on the back of each poster.
- Two handbooks – *AIDS in the community* and

  Living positive with HIV and AIDS

  These were developed to accompany the Soul City Series and are available in three languages.
- Three workbooks – *Living with HIV and AIDS;*

  Women, Children, and HIV and AIDS and

  Caring for a person with AIDS

  These workbooks are user friendly and have information and activities so that adult learners can work through the issues.
- Soul City video – *Lizzie and George's Story* –It is the same story as the comic and was based on characters from the Soul City television series 2 and 3. It follows the story of how Lizzie and George cope when they find out they are HIV positive. This is a multi lingual video with English subtitles.

This video looks at issues of –

- Transmission and prevention,
- Living positively with HIV
- The HIV blood test
- Stigma and discrimination
- Disclosure
- Care and support for people living with HIV and AIDS
- Death and dying.

- A user guide to help facilitators with the training process and use of the materials was also available.

These Soul City materials "use stories and characters to teach about HIV and AIDS. – making them popular and easy to use."[8] This method is the edutainment approach. The material was evaluated by the Community Agency for Social Enquiry (CASE) prior to the beginning of the training programme. The CASE evaluation showed that "overall usage of the material in organisations that had received it is 90%. The material seemed to be used fairly regularly by 80% of the organisations. Audience reception of the material was very positive, with on average more than 4 out of 5 organisational respondents rating the material as excellent. This positive reception extended to the end – user sample as well". The report concludes that the materials are of high quality and a "causal link can be made between Soul City materials and a positive change in behaviour and intentions". [8]

The cascade model of training has advantages such as being cost effective, flexible and enables capacity building and empowering of large groups of people.[36,37] The potential

disadvantage is the "dilution of the training".[35] This means that as one goes down the cascade the information distributed is less clear. However this problem can be prevented if the model is used correctly. If the programme is monitored and evaluated regularly the loss of accurate information should be minimised and thus quality of the training assured.[36,37]

The Soul City cascade training model should therefore result in people at the community level achieving adequate knowledge and skills in dealing with HIV/AIDS. This is one step on the way to decreasing the spread of HIV/AIDS. This type of training tries to empower people with knowledge and strives to encourage social educational messages like safe sex and positive care and support of people living with AIDS. Malcolm Steinberg et al in the 2000 South African Health Review states that "The greatest barrier to achieving HIV prevention is fear and ignorance. HIV prevention efforts have been plagued above all by silence brought on by denial and stigmatization that is associated with the disease." In order to change this people need to be educated. This is in keeping with the human rights approach that is endorsed as one of the guiding principles of the HIV/AIDS Strategic Plan (2000-2005). [9]

1.4 Evaluation methodology

Organisations develop goals or programs which must be reached to accomplish their mission. Therefore an evaluation of the training programme has to be done to determine if the objectives are being achieved, what the impact of the programme is and to see if the programme is efficient, effective and sustainable. Thus information about the program is collected so that decisions can be made.

"An evaluation is the process of systematically and objectively determining the value or significance of a development activity, policy, or program".[19]

A program theory has been used in the evaluation of the Soul City adult education training programme. This consists of:

Inputs → Processes → Outputs → Outcomes.

"Inputs are the various resources used to run the programme" [20]. In this evaluation this included money, facilities, master trainers and trainees.

"The processes are the actual activities carried out" [20] i.e. the-train-the-trainer workshops.

"The outputs are the units of service" [20] i.e. the number of workshops conducted and the number of peopled trained.

The outcomes of the project, however is improved knowledge, attitudes and behaviours of the public that were trained in the programme.

There are several ways in which an evaluation can be conducted. Some examples are the Goal-Based Evaluation, the Process–based Evaluation or the Outcomes –Based Evaluation. Goal-based evaluations assesses if the programs are achieving their overall predetermined objectives. Process-based evaluations help you understand how the programme really works and determines its strengths and weaknesses. The outcomes-based evaluation helps one identify if you are using the right programme activities to bring out the outcome you believe

is needed by the participants and these outcomes are of benefit to the participants. In this study a combination of the different processes was used. In this evaluation a combination of questionnaires, interviews and documentation reviews were used to obtain data.

Thus an evaluation can help uncover how and why a program, policy or project is expected to work and if it does not where is the problem. The result of this evaluation results in useful information to improve the programme.

High quality evaluations → Useful information →Better decisions[18]

1.5 HIV/AIDS training programmes

HIV/AIDS training programmes are often viewed as processes that can positively influence the knowledge, attitudes and practices of individuals doing the training. The benefits from this type of training are still unclear. This is due to the difficulty in attributing behaviour change to these training processes when there are many other factors out there that can contribute to the change. However in order to determine if any programme was effective in terms of positive behaviour, knowledge and attitude change, it needs to be evaluated.

In this study an evaluation of the Soul City Adult Education Training Programme in HIV/AIDS was conducted. The objectives of this training programme were:

- For Soul City to train and support HIV/AIDS training organisations who work at a local and regional level, to use Soul City HIV and AIDS training materials using the cascade model.
- For Soul City HIV and AIDS materials to be widely distributed through the training courses run by partner projects – especially in rural and under-resourced areas.
- To support the development of high standards of HIV and AIDS Information and skills at all levels of the community both in rural and in urban areas.

2. AIM OF THE EVALUATION

The aim of the study was to evaluate the effectiveness of the Soul City adult education training programme in HIV/AIDS.

2.1 Objectives

1. To evaluate the effectiveness of the training cascade model.

2. To determine the self reported impact on partner organisations and master trainers.

3. To determine the self reported impact of the training on knowledge, attitudes and practices and other aspects of an individual's life-community trainee level.

4. To determine if the management process influences the success of the programme in terms of the training, activities and distribution of materials.

In order to achieve this, input, process, output and outcome indicators were used. Specific objectives were developed for the different levels of the cascade being evaluated.

2.1.1 Managers and master trainers

- To assess who were the master trainers (MT) training.
- To determine if the Soul City master training provided is effective in terms of improving knowledge and training skills of the master trainers.
- To assess the impact of the training on the master trainer (MT) and on the organisation.
- To determine how well the administrative/ management process functions.

- To determine what improvements can be made to the programme.

2.1.2 Community trainees

- To assess who is being trained as a community trainee (CT).
- To determine if the training is effective in influencing knowledge, attitudes and behaviour of the community trainees.
- To determine if the messages coming out of the training are accurate
- To determine if the community trainees were accessing the training materials easily.
- To determine what the impact of the training is on the individuals' life.
- To determine if any improvements can be made to the training.

3. METHODOLOGY

The study consists of 2 sub- studies, conducted in July 2004. The 2 sub studies evaluated the managers and master trainers (A and B in the cascade) and then the community trainees (C in the cascade).

A. Training of master trainers (MT)
(From 14 partner organisations)
⇓
B. Master trainers (MT) train other trainers (CT)
⇓
C. These Community Trainees(CT) then train in their community
⇓
D. Education of community, families, individuals

The community or individuals in the community (D in the cascade) were not assessed because information regarding this group was obtained from a national survey conducted by Soul City. However although this would have strengthened this study it was not feasible at the time.

3.1 Sampling

3.1.1 Sampling of managers and master trainers *(Part A and B of the cascade*)

There are 14 partner organisations associated with the Soul City Training Programme. The partner organisations work throughout South Africa. However the distribution across the provinces was not equal, with certain provinces receiving more coverage than others. Thus even though the head office of a partner organisation is in one province, the master trainers

(MT) travel to other provinces to train or they have satellite branches in other provinces. A complete list of the managers and master trainers in each partner organisation was obtained from the training department in Soul City. The list was then stratified per province (according to where the partner organisations were based though not necessarily where they do training). The total number of managers and master trainers differed in each province. Thus in each province a proportionate random sample of master trainers and managers was obtained. Random sampling was conducted using a Microsoft Excel function to generate a list of random numbers in each province. The managers and master trainers (MT) are grouped together to enable a degree of confidentiality. This group consists of a total population of 84. A sample of 30 was used. This was based on achieving a 95% confidence level and a confidence interval of at least 10.

Inclusion criteria:

1. Attendance at the Soul City Train the Trainer workshop
2. A manager in a partner organisation.

3.1.2 Sampling of community trainees *(Part B & C of the cascade*)

Attendance registers of community trainees were recorded at each workshop conducted. Copies of these attendance registers were submitted to Soul City. These lists were obtained from the Soul City training department. The lists were then collated and stratified into provinces. The distribution across the provinces was not equal and thus a proportionate stratified random sample of community trainees (CT) was obtained. A list of random numbers was generated per province using a Microsoft Excel function. The number of community trainees (CT) from the period of June 2002 till June 2004 was 3294. A sample size of 265 was obtained for a 95% confidence level and 5% confidence interval.

Inclusion criteria:

1. Attendance at the Soul City workshop.

3.2 Methods of data collection

A semi-structured questionnaire was administered either telephonically or face to face. The questionnaire contained quantitative and qualitative questions. Qualitative questions were open ended questions. Refer to separate questionnaires for Managers and master trainers and Community trainees in Appendix C.

3.2.1 Methods of data collection on managers and master trainers

Managers and master trainers based in Gauteng were interviewed face to face (30%). Only the interviewee and the researcher were present at the interviews in order to maintain confidentiality regarding responses. All other managers and master trainers from the other provinces were interviewed telephonically (70%). This was done due to budget constraints and it was known that the participants had access to telephones. The demographics between those interviewed telephonically and those interviewed face to face differed in terms of where they are located geographically. All of these interviews were conducted in English by the researcher and all information or answers obtained were written down on the questionnaire.

3.2.2 Methods of data collection on community trainees

This questionnaire was also administered either telephonically or face to face. Interviewers were trained extensively by a research agency after detailed consultation with the researcher.

Eighty per cent (80%) of interviews were conducted face to face by the trained interviewers. The participants (20%) who were not available for direct face to face interviews were interviewed telephonically. These interviews were conducted in English or in the home language with the aid of a translator if needed. The interviewers interviewing techniques were monitored by the consultants of the research agency and 10% of questionnaires were back checked after the fieldwork. The completed questionnaires were then returned to the researcher for data entry and analysis.

3.3 Reliability and validity

The schedule of questions was designed from various questionnaires previously used by Soul City (obtained from Soul City). The questions on HIV/AIDS knowledge attitude, risk and behaviour, as well as the sensitive questions on HIV risk were previously tested and used by Soul City researchers.[25] The schedule of questions was also assessed in a pilot study conducted by the researcher. The pilot study was conducted to detect any unforeseen problems, to test the instrument for ambiguous and misleading questions and to assess the length and time it took to complete the questionnaire. The schedule was used in interviews with ten staff members who were chosen at random from the School of Public Health. The time taken for completion was between 40 to 60 minutes. Some of the pilot study subjects had problems in answering specific items, the questionnaire was therefore revised by changing the wording of the questions and adding further items. By performing the above exercise and using already tested tools from Soul City the researcher attempted to improve the reliability and validity of the study.

3.4 Analysis of data

Quantitative data obtained from the interviews was captured and entered. A double entry was done to enable more accurate data capturing. The data was then analysed using the SPSS Statistical package. The qualitative data was coded post data collection and analysed thematically.

3.4.1 Analysis of data on Managers and Master Trainers

- Descriptive statistics such as frequencies were presented.
- Chi squared tests were used to compare the study sample and study populations. The significance level of 5 % was used.
- In the qualitative data analysis the participants that had face to face interviews had slightly better quality in their answers. However the responses from those interviewed telephonically was adequate.

3.4.2 Analysis of data on Community Trainees

The following statistical analyses were done.

a. Descriptive statistical techniques such as frequencies and cross tabulations were used.

b. Analytical statistics

- A chi square test was used to determine the differences in responses to questions among the different groups listed in table 3.1 below. A significance level of 5% was used.

Table 3.1 Variables used in analysis of Knowledge, Attitude, Risk, and Behaviour questions.

Variables	**Type**
Sex	Male and Female
Age in years	<20 , 20-40, 41-60, >60
Geographical area	Urban formal, Urban informal, Rural

- A detailed analysis was done to explore what influence various variables mentioned in table 3.2 might have on condom use. A stratified analysis was conducted and all variables significantly associated with condom use were determined. A further stratification was done to exclude the effects of confounders or effect modifiers on the results. The odds ratio and 95% confidence interval was obtained. The Woolf Test of heterogeneity was used to confirm if there was any interaction. If the P value was significant then the interaction was present, however if it was insignificant there is no interaction.

Table 3.2 Variables used in the logistic regression analysis

Dependent variable	**Type**
Condom use	Always, not always
Dependent variables	**Type**
Sex	Male and female
Age in years	<20 , 20-40, 41-60, >60
Geographical area,	Urban, informal settlements, rural
Educational status	None, primary, secondary, tertiary
Occupation	Employed full time, employed Part time, Unemployed
Number of partners	1 partner and more than one partner

3.5 Ethical considerations:

The ethical clearance was obtained from the University of the Witwatersrand Human Research Ethics Committee prior to commence4ment of the study. The clearance certificate number is: H 040705

Permission to interview managers and master trainers was obtained from the NGO Partners. Permission to tape interviews was also obtained from participants.

An information sheet was given to all participants. It was explained clearly that participation was voluntary and that they could refuse to participate or withdraw at any time during the interview. Consent forms were given to each interviewee either directly or by fax.

Every effort was made to ensure that confidentiality was maintained, these efforts was explained to participants. No names or other personal data were recorded. Codes were assigned to each participant. These codes were only known to the researchers involved in the project. In order to protect anonymity amongst Master Trainers and Managers, only provinces are referred to and not individual organisations.

4. RESULTS

4.1 Managers and master trainers

4.1.1 Demographics

4.1.1.1. Distribution of sample across the provinces[†].

A total of 30 managers and master trainers (MT) were interviewed. The majority of the sample trained in the Eastern Cape (30%); Limpopo however had the least amount of managers or master trainers at only 10%. This is reflected in Table 4.1.

Table 4.1 Where training by master trainers and managers took place*

Provinces	**Sample: Number (%)**
Gauteng	7 (23)
Kwa-Zulu Natal	7 (23)
Limpopo	3 (10)
Mapumalanga	4 (13)
Northwest	4 (13)
Eastern Cape	9 (30)
Northern Province	5 (17)
Western Cape	7 (23)
Free State	4 (14)

(Note that more than one answer was acceptable therefore the total is greater than a 100%)

***** The training often took place in a province different to where they were based.

[††] Where the master trainers have conducted their training

Table 4.2 Demographic characteristics of the sample of managers and master trainers and population of managers and master trainers

Demographic profile	Sample Number (%)	Population Number (%)	P value
Sex			
Male	11 (37)	26 (31)	
Female	19 (63)	58 (69)	
Total	**30 (100)**	**84 (100)**	**0.73**
Age category (years)			
<20	0	0	
21-40	13 (43)	28(33)	
41-60	16 (53)	52(62)	
>61	1(3)	4 (5)	
Total	**30 (100)**	**84 (100)**	**0.6**
Race			
African	18 (60)	39(46)	
White	10 (33)	41(49)	
Coloured	2 (7)	4(5)	
Asian/ Indian	0	0	
Total	**30 (100)**	**84 (100)**	**0.3**

4.1.1.2 Demographic characteristics of the sample of managers and master trainers

Table 4.2 shows that the majority of the sample was female (63%). The age range was from 23 years to 72 years. The majority of participants were between 41-60 years (53.3%). In the sample 60% (18) were African, followed by 33% (10) White participants. There were no Asian participants in the sample. There was no significant difference between the sample and the study population in terms of sex, age or race, as assessed by the chi square test. (P value >0.05)

4.1.1.3 Languages

Figure 4.1 shows that the commonest language spoken was Xhosa at 27%, followed by English and Afrikaans at 20% each. The other 3 languages – Setswana, Zulu, and South Sotho were spoken to a lesser degree.

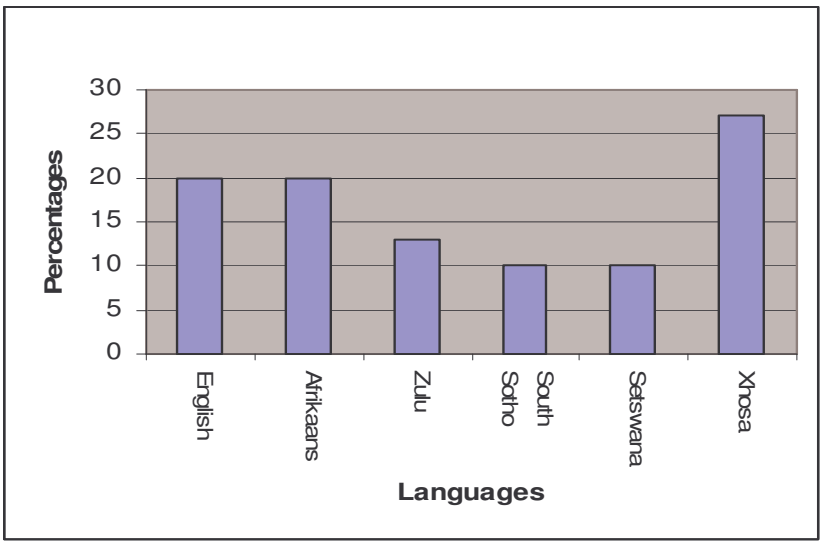

Figure 4.1 Languages spoken by managers and master trainers

4.1.1.4 Level of Education

Seventy three percent (22) had some form of tertiary education. The remainder of 27% (8) had completed secondary level of education. This indicated that the master trainers (MT) and managers had high levels of education.

4.1.1.5 Length of time in the organisation

Length of time in the organisation ranged from 6 months to 12 years. The average time in an organisation was 4 years

4.1.1.6 Position in organisation

There was almost an equal distribution of master trainers (37%) and managers sampled (40%). This is demonstrated in figure 4.2.

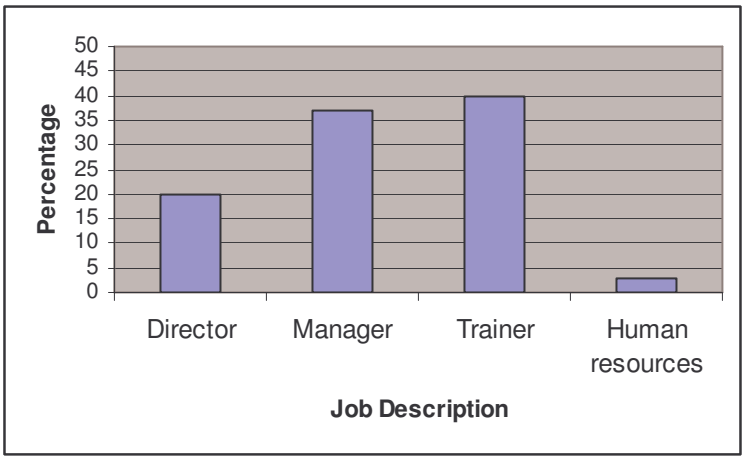

Figure 4.2 Position in organisation

4.1.2 Training done by master trainers

In this section the results of the master trainers (MT) training of community trainees (CT) is shown. As described earlier the master trainers of the 14 partner organisations conducted workshops using the Soul City material to train others from other NGO's, CBO's etc.
The training occurred in all nine provinces. The distribution is described in section 4.1.1, table 4.1.

4.1.2.1 The rural urban distribution of training

The distribution between rural and urban areas showed that the majority of participants performed their training in urban formal areas (80%), followed by urban informal (60%) and

then rural (57%).The totals are greater than a 100% since some trainers trained in more than one geographical setting. This is shown in figure 4.3.

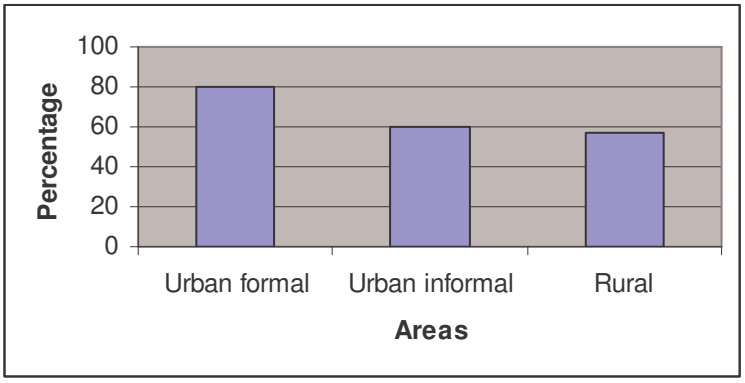

Figure 4.3 Geographical distribution of the training

4.1.2.3 Number of workshops conducted

A total of 638 workshops were conducted over the period of January to December 2003. The range per organisation was 0 – 100 workshops, with the mean of 21. These were all the workshops on HIV/AIDS related issues, which included the Soul City workshops. 300 of the 628 workshops were dedicated Soul City workshops and were funded by Soul City. Soul City material was used in all 300 Soul City workshops.

The remaining 338 workshops were not funded by Soul City. These workshops (338) were funded by the partner organisations. However Soul City materials were also used in these workshops, in addition to other materials. All of these topics dealt with various aspects of HIV/AIDS.

All master trainers (MT) provided community trainees (CT) with Soul City

material to take home. Therefore in the 300 Soul City Train the Trainer workshops, a 100% of master trainers gave the community trainees Soul City materials to take home.

Majority of the Soul City workshops occurred at the location of the communities. This meant that 83% (25 out of the 30) of participants conducted their training within the community. Thirty three percent (10 out of the 30) conducted the training at their headquarters or offices.

4.1.2.4 Recruitment of community trainees

Recruitment of community trainees follows several processes that are illustrated in Table 4.3

Table 4.3 Recruitment procedure of organisations (n=30)

Recruitment procedure	**Number (%)**
1. Send invitations to NGO's or invited by them	12 (40)
2. Via word of mouth	14 (47)
3. Key people/organisations in community help recruit*	5 (17)
4. Advertise in newspaper	4 (13)
5. Asked by Department of Health or Education to train staff	3 (10)
6. Community health workers on payroll.	1 (3)
7. Link training to TB Dots network.	1 (3)
8. People come off the street	1 (3)
9. Approach youth out of schools- peer educators	1 (3)

(∗ Key people/ organisations = clinics, churches, schools and Traditional leaders.)

Forty seven percent of community trainees heard about the training from a source other than the partner organisation itself and came to the organisations requesting training. Forty percent were recruited from other non-governmental organisations.

4.1.2.6 The percentages of the different types of people trained by the master trainers:

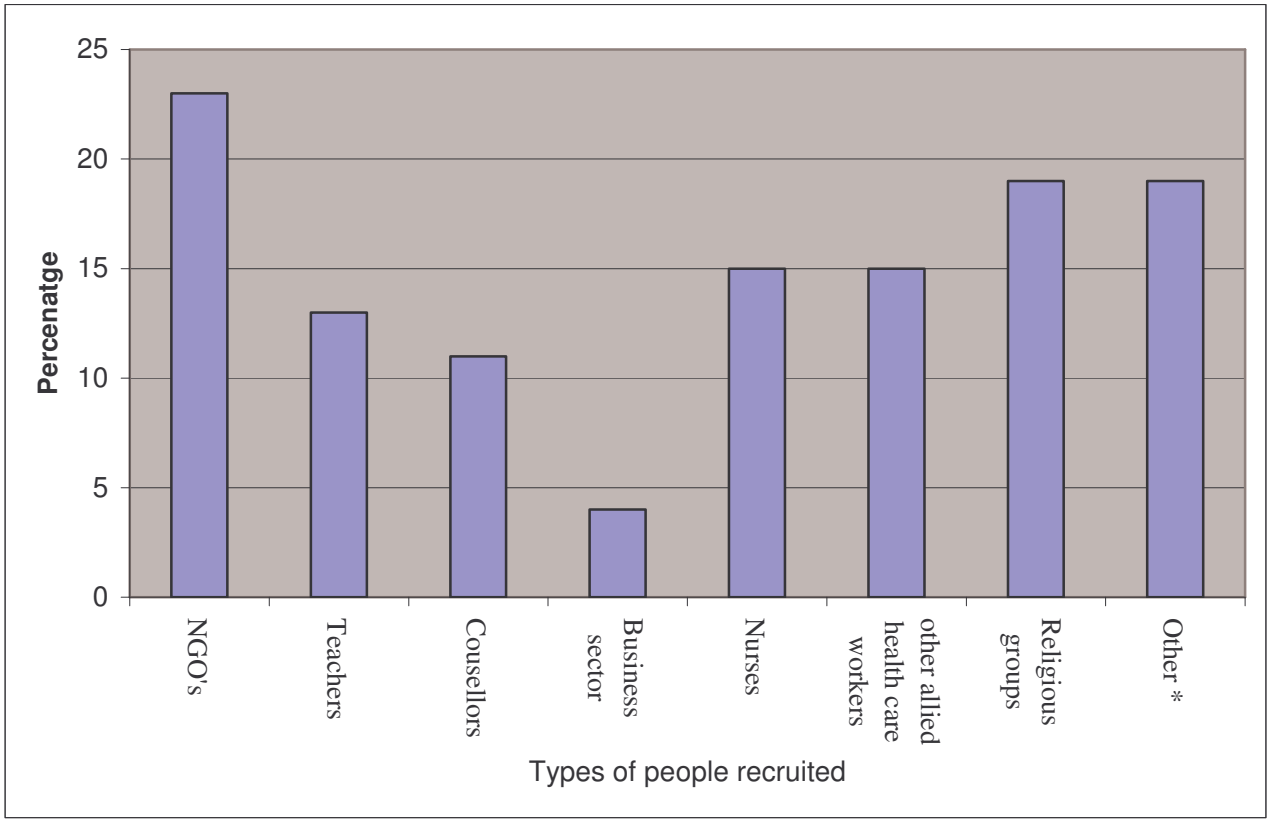

Figure 4.4 Types of people trained by master trainers

∗Other = government sector, unemployed, volunteers, community members, district officials of the Department of Education, School children, youth workers in community, parents of children, field workers and community based organisations.

Thus members of other non-governmental organisations were also trained. The majority of people trained appeared to be well educated.

4.1.2.7 Follow up of community trainees by partner organisations

In order to ensure that the cascade is working effectively partner organisations should have followed up on the community trainees. Seventy seven percent (77%) had actually followed up when a community trainee called the organisation requesting more material (passive follow –up).

4.1.2.8 Support offered to community trainees post training.

The majority of partner NGO's provided some support to the community trainees after the training. This is illustrated in Table 4.4 below.

Table 4.4 Types of support provided by Partner Organisations (n=30)

Type of Support provided	Number (%)
Resource centre for information	21 (70)
Provided Soul City Contact Details	12 (40)
Provided other relevant materials	12 (40)
Assisted with Workshops	8 (27)
Refer to other agencies	1 (3)
None	2 (7)

(Total greater than 100% since multiple answers was acceptable).

4.1.2.9 Improvements needed in the training

Eighty seven percent (26 out of the 30) thought that the training they presented to the community trainees could be improved. Table A1 in appendix A has the detailed responses. The following reasons were given:

- Training time is too short.
- Needed greater access to materials especially the video.

- Content of the material requires updating and more information on counselling and treatment needs to be added.
- Generally always room for improvement.

4.1.2.10 Challenges faced by managers and master trainers

Sixty percent (18) did not experience any problems with the training. The remaining 40% did experience problems related to:

- The material was not available in certain languages.*
- Venue and transport related problems.
- More information is needed in topics such as Pregnancy and HIV.
- Length of time of the train the trainer workshops are inadequate.
- Some of the material is outdated.
- Unable to train all who want training.

* Currently the material is available in a number of languages. However initially, at the start of the programme, it was available only in English and a few partner organisations ordered large stocks of it in English. Thus these partner organisations are still using the initial stock, and have not ordered the new booklets in other languages. Table A2 in Appendix A illustrates the full list of comments.

4.1.3 Assessment of the impact of the training

4.1.3.1 The impact of the training on the organisation

A hundred percent (100%) of participants stated that the Soul City training had a positive impact on their organisation. Table A3 in Appendix A, has detailed comments by all participants.

The following themes emerged form the analysis of the responses:.

- **The Soul City material strengthened the organisation:**
    - "*I learnt a number of things. It was enriching. Some of the questions in the training sessions have helped in our own development. We have learnt a lot from the Soul City training."* [Female rural]
    - **"***It has an incredible impact. It made us far more aware of HIV/AIDS. We would not have had this level of awareness professionally or on an individual level if not for Soul City."* [Female rural]

- **We were able to reach more people:**
    - **"***No financial benefit to the organisation. However it is of benefit to me as a training manager and from the people's point of view, since it touches people's lives. It also gave us an opportunity to go to where people really needed us."* [Female urban]
    - *"For the first time we had something to give to people. – knowledge about HIV/AIDS*". [Female rural]

- "*More information in an easy to use way in the Soul City material , than in the X manual and love life material (X &love life are in partnership). The Soul City material can be used in different communities and the video is important. The organisation can train more easily."*[Male rural]

- **The impact would be greater if we could sort out problems:**
  - "*Would have a bigger impact if the financial aspect sorted out. If this is sorted out can get more trainers and do more training and be more effective*" [Female urban]

A hundred percent (100%) said that the partnership with Soul City increased the amount of training that they do.

4.1.3.2 The impact of the training on the participants

The participants were asked if there was an improvement in the following aspects of their lives because of the training.[‡]

Table 4.5 The personal impact. (n=30)

Improvement in the following aspects listed	Yes	No
	Number (%)	Number (%)
Knowledge on HIV	24 (80)	6 (20)
Attitudes regarding HIV/AIDS	21 (70)	9 (30)
Training skills	24 (80)	6 (20)
Presentation Skills	26 (87)	4 (30)

[‡] The sample included managers and master trainers

Over all aspects, 79% stated that there was improvement in their knowledge and skills. Only 21% stated that there was no overall improvement. The reason for this was that they have been training for many years and thus felt that they already possessed the appropriate knowledge and skills.

4.1.3.3 Additional opportunities for partner organisations because of the training.

Eighty three percent (25) said that their organisation had other opportunities because of Soul City. This occurred mainly because of improved recognition due to the association with the Soul City brand name and resulted in more work being offered to the partner organisation by sectors in the government and other non governmental sectors. This is illustrated in the quotes listed below:

- "We have been d*rawn into other HIV initiatives and have more contacts since association with Soul City. Our exposure has increased."* [Urban male]
- "*The association with Soul City adds credibility to the organisation. People identify with it immediately."* [Urban Male]
- "*Because it is a winning brand and because X is a preferred service provider for Soul City it has influenced and contributed to X – given us credibility."* [Urban Female]
- *Yes, because of association with Soul City X has become a resource for other organisations in the Eastern Cape*." [Rural Female]

(Table A4 in Appendix A has a full list of quotes representing this point.)

4.1.4 Evaluation of the administration processes

4.1.4.1 Rating of the partnership with Soul City

The participants rated the partnership with Soul City on a scale of 1-10 (1 being the worst and 10 the best). The score ranged from 5 to 10. The median was 8.

4.1.4.2 Administrative challenges experienced by respondents

In relation to the administration 53% (16) of the respondents were happy (See table 4.6).

Table 4.6 Administrative problems encountered by master trainers and managers (n=30)

Problems in relation to:	Yes	No	I don't Know
	Number (%)	Number (%)	Number (%)
Money paid by Soul City to partner NGO	14 (47)	9 (30)	7 (23)
Supervision from Soul City	12 (40)	18 (60)	0
Difficulty in writing reports to Soul City	4 (13)	25 (83)	1 (3)
Lack of feedback from Soul City	1 (3)	0	0
Materials not arriving on time	1 (3)	0	0

(Totals are greater than a 100% since more than one answer was acceptable)

Seventy percent (21) stated that there were aspects of the administration that were good. Twenty seven percent (8) did not know, since they had no contact with the administration and were only involved in the training.

4.1.4. 3 Additional support needed from Soul City

A need for additional support from the administration was expressed by 76.7% (23) of respondents. Table A5 in appendix A has the complete data for recommendations made by the master trainers and managers.

The following themes were prominent from the comments received**:**

- **Increase the amount of work done with Soul City.**
  - "*We would like to extend the partnerships. To do larger projects since we have the capacity and the knowledge and a good training model. We can add value to Soul City. Therefore can be involved in a large scale with Soul City."* [Urban Female]

- **Require more information.**
  - "*Soul City needs to provide any updated information. And give us more videos- we only have one and we have 6 trainers going out to train. If they can vary the videos, this would be helpful also*." [Urban Male]
  - "*It would be nice to give out a newsletter with updates. Need up to date information on HIV/AIDS for example the controversy around nevirapine. Also the book given to journalists on background information was very useful. Should get more like that."* [Rural/ Urban Female]
- **Communication/ more discussions.**
  - "*Working closer with them (*Soul City*), provide guidance in some areas, debate ways and means of behaviour change, what is not working well."* [Urban Male]

- "*Besides the actual training, it is important to come back physically and discuss the challenges and strengths of the Soul City training. Once a year Soul City should call all its master trainers and have a 2-3 day feedback session."* [Rural/ Urban Male]

- **Establishing more partners in some areas**
  - *"We need more partners in this area (Northern Cape). We work in Kimberly, but the other areas are so far that it is very taxing to get there, for example to go to Springbok, need to travel for a whole day. We are over extending ourselves. We are in a position to refer to other agencies. We did this once in the Siyanda district."*[Urban Male]]

- **Accreditation**
  - "*Facilitating a process of accreditation for this course. Then they* (Soul City) *can certify people."*[Urban Male]

- **Increase visibility with more promotional items.**
  - "*Instead of more money going into films, it should go into promotional material like Soul City T-shirts etc. Love life is more visible and more people know it."* [Urban Male]
  - "*Also it would be good if we had some visible thing like a cap, t shirt or jacket with the Soul City and X emblem to show the partnership with Soul City. Since*

sometimes people say that you can obtain these books for free so you need other forms of confirmation of the association with Soul City." [Urban Female]

- **Support the trainees.**
  - *"There needs to be provision for supporting the trainees- follow up or give them advice or help with resources. People trained in some areas but because they don't have resources/ empowerment to continue the training nothing gets done. Capacity out there is limited. Therefore we have to go out again to some areas and do training for the whole community instead of the trainees doing it."* [Rural/ Urban Female]

- **More videos.**
  - "*Get more videos-so that we can give it to people. People like it and relate to the characters."* [Rural Male]
  - *"And give us more videos- we only have one and we have 6 trainers going out to train."* [Urban Male]

4.2 Community trainees (CT)

4.2.1 Demographics

4.2.1.1 Distribution of community trainees

Table 4.7 Distribution of community trainees in the provinces. (n=265)

Province	**Sample Number (%)**	**Study Population Number (%)**
Gauteng	73 (28)	922 (28)
KZN	37 (14)	461 (14)
Limpopo	0	0
Mpumalanga	0	0
North West	3 (1)	33 (1)
Eastern Cape	109 (41)	1350 (41)
Northern Cape	22 (8)	264 (8)
Western Cape	13 (5)	165 (5)
Free state	8 (3)	99 (3)
Total	**265 (100)**	**3294 (100)**

A total of 265 community trainees were interviewed. The community trainees were randomly and proportionally selected from each province. The majority of community trainees were from the Eastern Cape (109). There were no community trainees from Limpopo province and Mpumalanga because at the time of the study trainee registration forms were not received from these areas. Thus in the following parts of the analysis –Limpopo and Mpumalanga were excluded.

The area where the training was conducted for the community trainees is shown in Figure 4.6.

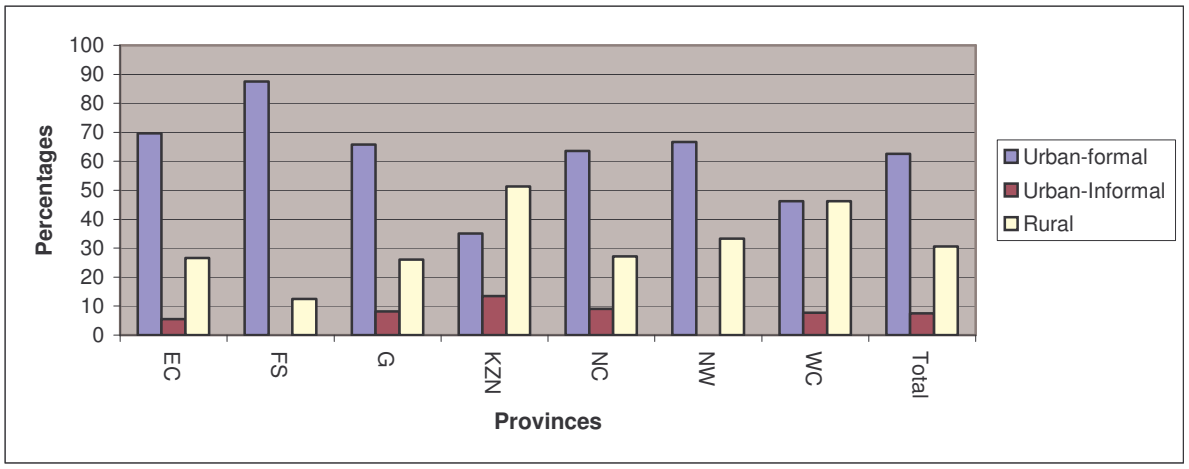

Figure 4.6 Rural and urban distribution of community trainees in provinces.

The above graph shows that the majority of the training occurred in urban formal areas- 62.6% (166). Very little training occurred in the informal urban sector -7.5% (20). With only 30% (81) of all training occurring in the rural areas- this indicated poor rural coverage.

4.2.1.2 Sex of the respondents

Eighty five percent (225) off all community trainees were female, with only 15% (40) being male. This gender difference was seen across the provinces and in rural and urban areas.

Table 4.8 Sex distribution of community trainees in the provinces. (n=265)

Province	Sample	
	Male	Female
	Number (%)	Number (%)
Gauteng	11 (15)	62 (85)
KZN	3 (8)	34 (92)
North West	0	3 (100)
Eastern Cape	19 (17)	90 (83)
Northern Cape	7 (32)	15 (68)
Western Cape	0	13 (100)
Free State	0	8 (100)
Total	**40 (18)**	**225 (85)**

4.2.1.3 Age range

Majority of community trainees were between 21-40 years in both the rural and urban areas. There was virtually no training of the youth. Only few people over 60 were trained in certain provinces.

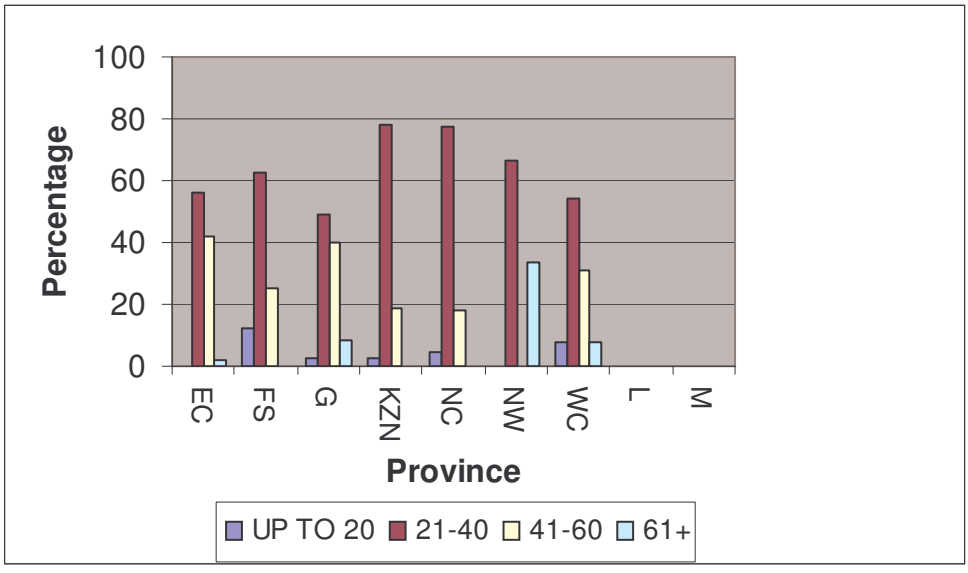

Figure 4.7 Age distribution of community trainees

4.2.1.4 Employment status

The majority of people who were trained were employed full time- 39 % (103), followed by 30% (80) having some employment and then the unemployed at 26% (69). Appendix B Table B1 shows the full details.

4.2.1.5 Educational qualification

The educational status of the community trainees reflects that mainly literate educated people were being trained, the majority has secondary (39%) or tertiary (32.5%) levels of education. This is similar in urban and rural areas.

4.2.1.6 Languages

The majority of the participants spoke Xhosa (45.7%), followed by Zulu (15.8%) and Setswana (15.1%). There were 1.5% English speaking and 6.4% Afrikaans speaking participants in the sample.

The booklets are available in 4 languages – English, Afrikaans, Xhosa and Zulu. There have been a few community trainees and master trainees who have had problems with the booklets not being in other languages. However this may have been due to some partner organisations providing the booklets only in English to the trainees or people may need the booklets in more than the 4 languages currently available.

4.2.1.7 Race

The majority of the community trainees were African- 92.5% (245), followed by Coloured at 7.2% (19). One of the issues highlighted here was that virtually no training in the White or Indian community occurred.

Thus overall Soul City partners are training mainly young African urban female educated individuals.

4.2.2 Effectiveness of the training

4.2.2.1 Knowledge/ attitude

Community trainees were asked a set of 16 questions. The results were very positive.

Table 4.9 Scoring of participants in assessing knowledge and attitude (n=265)

Scoring	**High**	**Medium**	**Low**
No. of wrong answers	0-2	3-4	>4
	Number (%)	**Number (%)**	**Number (%)**
No. of trainees	220 (83)	42 (16)	3 (1)

One question was not answered well. Almost a third of community trainees thought that an HIV positive woman could not pass HIV to her baby. Overall all other questions on knowledge and attitude were answered correctly by over 80% of the community trainees. Table B2 in Appendix B has the full results.

In Table 4.10, 4.11 and 4.12 below, differences in knowledge and attitude were assessed for age groups, sex and geographical area. Answers were marked correct based on information from the Soul City Adult Education Material.

Chi square tests were used to assess if there is any significant differences in response (agree, disagree, don't know) among the different age groups (<20 / 20-40 / 41-60/ >60). The test values for each question were reported separately. Table 4.10 highlighted specific questions that revealed differences between the age groups. Question l showed significant differences in the answer between the different age groups. Those under 20 years of age were less likely to agree with the statement that HIV positive people have the same rights as everyone else.

Table 4.10 Differences between age groups in Knowledge and Attitude (<20: n=6, 21-40: n=157, 41-60:n=92, >60: n=10)

Statements	Agree (%)				Disagree (%)				Don't know (%)				P value*
	<20	21-40	41-60	>60	<20	21-40	41-60	>60	<20	21-40	41-60	>60	
a.Having an HIV test is the only way to know if you have HIV or AIDS.	100	94.9	98.9	100	0	5.1	1.1	0	0	0	0	0	0.9
b.There is nothing you can do to prevent getting HIV and AIDS.	33.3	12.7	8.7	0	66.7	87.3	91.3	100	0	0	0	0	0.6
c.Once HIV is in your body, it never goes away.	100	93.6	95.7	100	0	6.4	4.3	0	0	0	0	0	0.9
d.There is a difference between HIV and AIDS.	100	96.8	95.7	80	0	3.2	4.3	20	0	0	0	0	0.2
e.You can tell from looking at a person that they have HIV.	0	12.1	13.1	30	100	87.9	86.9	70	0	0	0	0	0.07
f.People with HIV/AIDS should be kept away from other people.	0	3.2	4.4	0	100	96.8	95.6	100	0	0	0	0	0.7
g.It is safe to touch and hold someone who has HIV/AIDS.	100	94.3	92.4	90	100	5.7	7.6	10	0	0	0	0	0.4
h.An HIV positive woman cannot pass HIV to her baby.	66.7	31.2	28.3	30	33.3	68.2	71.7	70	0	0.6	0	0	0.9
i.It is safer for a women who is HIV positive to have an c- section (operation) rather than a normal birth.	50	67.5	68.5	90	50	31.2	29.3	10	0	1.3	2.2	0	0.9
j.There are no medicines to cure HIV.	100	87.3	90.2	80	0	12.7	9.8	20	0	0	0	0	0.4
k.Antiretroviral drugs slow the progression of AIDS but don't cure it.	100	96.8	98.9	100	0	2.6	1.1	0	0	0.6	0	0	0.9
l.HIV positive people have the same rights as everyone else?	83.3	99.4	98.9	90	0	0.6	1.1	10	0	0	0	0	0.006
m.People living with HIV & AIDS need support from the community.	100	100	100	100	0	0	0	0	0	0	0	0	0
n.It is good to talk openly about being HIV positive.	100	99.4	98.9	100	0	0	1.1	0	0	0.6	0	0	0.9
o.HIV/AIDS affects everyone in the community in some way.	100	94.3	92.4	90	0	5.7	7.6	10	0	0	0	0	0.9

*Counts were used in the Chi square test used to calculate p values, however only the percentages are reflected in the table.

In Table 4.11 differences in knowledge and attitude were assessed for the different sexes. Chi square tests were used to assess if there is any significant differences in responses (agree, disagree, don't know) among the different sexes (male and female). The test values for each question were reported separately. This table highlighted specific questions, a, d and h, that revealed differences between the sexes. In question a, a significantly greater proportion of females thought that having a HIV test was the only way to know if you have HIV or AIDS (P value=0.025). In question d, a significantly greater proportion of females thought that there is a difference between HIV and AIDS (P value=0.04). In question h, a greater proportion of males disagreed with the statement that a HIV positive women cannot pass HIV to her baby (P value=0.05).

Table 4.11 Differences between males and females in Knowledge and Attitude (M= Male, n=40) (F=Female, n=225)

	Statements	Agree %			Disagree %			I don't' know %			P value*
		Total	M	F	Total	M	F	Total	M	F	
a.	Having an HIV test is the only way to know if you have HIV or AIDS.	96.6	90	97.8	3.4	10	2.2	0	0	0	0.025
b.	There is nothing you can do to prevent getting HIV and AIDS.	11.3	20	9.8	88.7	80	90.2	0	0	0	0.06
c	Once HIV is in your body, it never goes away.	94.7	92.5	95.1	5.3	7.5	4.9	0	0	0	0.5
d	There is a difference between HIV and AIDS.	95.8	90	96.9	4.2	10	6.7	0	0	0	0.04
e	You can tell from looking at a person that they have HIV.	12.8	10	13.3	87.2	90	86.7	0	0	0	0.6
f	People with HIV/AIDS should be kept away from other people.	3.4	2.5	3.5	96.6	97.5	96.4	0	0	0	0.7
g	It is safe to touch and hold someone who has HIV/AIDS.	93.6	90	94.2	6.4	10	5.8	0	0	0	0.3
h	An HIV positive woman cannot pass HIV to her baby.	31.3	27.5	32.0	68.3	70.0	68.0	0.4	2.5	0	0.05
i	It is safer for a women who is HIV positive to have an c-section (operation) rather than a normal birth.	68.3	70	68.0	30.2	27.5	3..7	1.5	2.5	1.3	0.8
j	There are no medicines to cure HIV.	88.3	85	88.9	11.7	15.0	11.1	0	0	0	0.5
k	Antiretroviral drugs slow the progression of AIDS but don't cure it.	97.7	97.5	97.8	1.9	2.5	1.8	0.4	0	0.4	0.9
l	HIV positive people have the same rights as everyone else?	98.5	100	98.2	1.5	0	1.8	0	0	0	0.4
m	People living with HIV & AIDS need support from the community.	100	100	100	0	0	0	0	0	0	No diff
n	It is good to talk openly about being HIV positive.	99.2	100	99.1	0.4	0	0.4	0.4	0	0.4	0.8
o	HIV/AIDS affects everyone in the community in some way.	94	95	93.8	6 .0	5.0	6.2	0	0	0	0.8

*Counts were used in the Chi square test used to calculate p values, however only the percentages are reflected in the table

Table 4.12 showed that there were only significant differences between areas for questions b (P value =0.02) Thus coming from and training in the different areas, did not contribute significantly to differences in knowledge and attitude

Overall there was not much difference between male and female, the age group or the area where training was conducted.

A cross tabulation was also done to determine the influence of educational status on knowledge and attitude. This showed no differences between the different levels of education and their knowledge and attitude towards HIV/AIDS. (P value >0.05)

Table 4.12 Answers cross tabulated with areas where training is conducted (UF, n= 166; UI, n=19; R, n=80)

	Statements	Agree (%)			Disagree (%)			Don't know (%)			P value
		UF	UI	R	UF	UI	R	UF	UI	R	
a	Having an HIV test is the only way to know if you have HIV or AIDS.	96.4	100	96.2	3.6	0	3.7	0	0	0	0.8
b	There is nothing you can do to prevent getting HIV and AIDS.	6.6	26.3	17.5	93.4	73.7	82.5	0	0	0	0.02
c	Once HIV is in your body, it never goes away.	95.2	94.7	93.7	4.8	5.3	6.2	0	0	0	1
d	There is a difference between HIV and AIDS.	95.8	89.5	97.5	4.2	10.5	2.5	0	0	0	0.4
e	You can tell from looking at a person that they have HIV.	13.2	10.5	12.5	86.7	89.5	87.5	0	0	0	1
f	People with HIV/AIDS should be kept away from other people.	3.6	0	3.7	96.4	100	96.2	0	0	0	0.8
g	It is safe to touch and hold someone who has HIV/AIDS.	92.2	89.5	97.5	7.8	10.5	2.5	0	0	0	0.5
h	An HIV positive woman cannot pass HIV to her baby.	25.9	31.6	42.5	73.5	63.1	57.5	0.6	0	0	0.4
i	It is safer for a women who is HIV positive to have an c- section (operation) rather than a normal birth.	62.6	78.9	77.5	35.5	15.8	22.5	1.8	5.3	0	0.2
j	There are no medicines to cure HIV.	89.1	84.2	87.5	10.8	15.8	12.5	0	0	0	0.9
k	Antiretroviral drugs slow the progression of AIDS but don't cure it.	97.0	94.7	98.7	2.4	5.3	0	0.6	0	0	0.9
l	HIV positive people have the same rights as everyone else?	98.8	100	97.5	1.2	0	2.5	0	0	0	0.8
m	People living with HIV & AIDS need support from the community.	100	100	97.5	0	0	0	0	0	0	0
n	It is good to talk openly about being HIV positive.	99.4	100	97.5	0	0	1.2	0.6	0	1.2	0.9
o	HIV/AIDS affects everyone in the community in some way.	94.0	89.5	93.7	6.0	10.5	5	0	0	0	0.8

*Counts were used in the Chi square test used to calculate p values, however only the percentages are reflected in the table

4.2.2.2 Behaviour

Self reported behaviour was assessed to see if the respondents put their knowledge into practice. Very positive results were obtained.

Sexual Activity

Seventy nine percent (79%) of community trainees were sexually active. There was no difference between the urban or rural areas.

The distribution across the provinces was similar except in the Free State where 50% were sexually active. Appendix B table B3 illustrates distributions within the provinces. Fifteen percent (15%) of males and 21.8% of females were not sexually active.

Range of sexual partners over the past 12 months

Of the trainees who were sexually active (210), the number of sexual partners in the past 12 months ranged from 1 to 6. The majority had only 1 partner: 92.9% (195 of 210).

The sex distribution showed that the majority of males and females had only 1 partner.

Table 4.13 The number of partners of male and female community trainees

No of partners	No. of sexually active participants (%) [n=210]	Number of male trainees (%) [n=34]	Number of female trainees (%) [n=176]
1	195 (92.9)	28 (82.4)	167 (94.9)
2	9 (4.3)	3 (8.8)	6 (3.4)
3	3 (1.4)	2 (5.9)	1 (0.6)
4	1 (0.5)	1 (2.9)	0
5	1 (0.5)	0	1 (0.6)
6	1 (0.5)	0	1 (0.6)
Total	**210**	**34 (16.2)**	**176 (83.8)**
Median		**1.5**	**1**

The Mann Whitney test showed that males and females did not have a significant difference in terms of the number of partners (P value=0.8).

Condom use in people who are sexually active

Fifty three percent of the 210 community trainees always used a condom. However almost one third never used condoms and 14% seldom used condoms.

The Chi-square statistic showed that there was no significant difference between males and females in terms of condom use. (P value =0.4) The statistical significance was influenced by the relatively small number of males in the study sample.

Table 4.14 Condom use by community trainees (n=210, Male =34, female =176)

Condom use	Total	Male	Female
	Number (%)	Number (%)	Number (%)
Always	111 (53)	22 (64.7)	89 (50.6)
Often	9 (4)	1 (2.9)	8 (4.5)
Seldom	29 (14)	3 (8.8)	26 (14.8)
Never	61 (29)	8 (23.5)	53 (30.1)
TOTAL	**210 (100)**	**34 (16.2)**	**176 (83.8)**

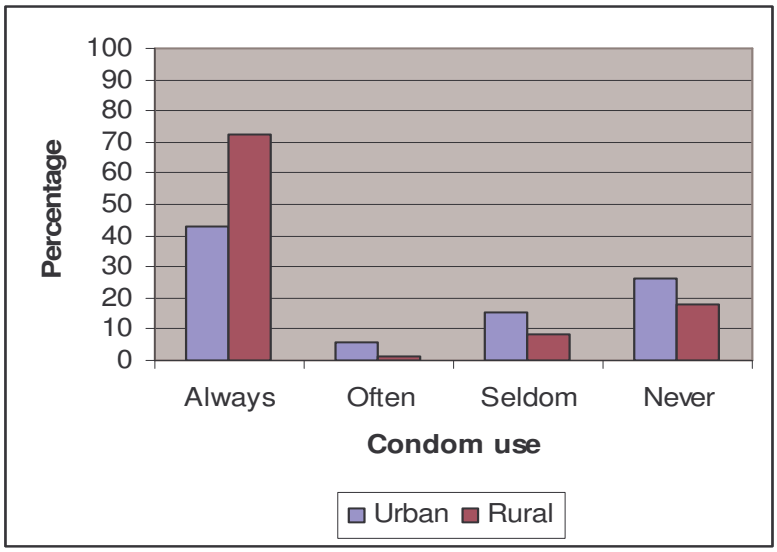

Figure 4.8 The urban vs. rural distribution of condom use.

Figure 4.8 shows that over 70% of the rural community trainees would always use a condom compared to only 42.8% of the urban community trainees. The chi square test revealed that people in rural areas had significantly higher condom use than the urban areas. (P value= 0.04)

Condom use was then compared with the number of sexual partners. The figure 4.9 and table 4.15 showed that the majority with 1 partner would always use condoms.

Table 4.15 Relationship with the number of partners and condom use. (n=210)

NO. OF PARTNERS (number of CT in brackets)	**Condom use**				
	NO ANSWER	**ALWAYS**	**OFTEN**	**SELDOM**	**NEVER**
	Number (%)	**Number (%)**	**Number (%)**	**Number (%)**	**Number (%)**
I (195)	38 (20)	81 (42)	8 (4)	20 (10)	48 (25)
2 (9)	2 (22)	3 (33)	0	0	4 (44)
3 (3)	0	2 (67)	0	0	1 (33)
4 (1)	0	1 (100)	0	0	0
5 (1)	0	0	0	1 (100)	0
6 (1)	0	1 (100)	0	0	0

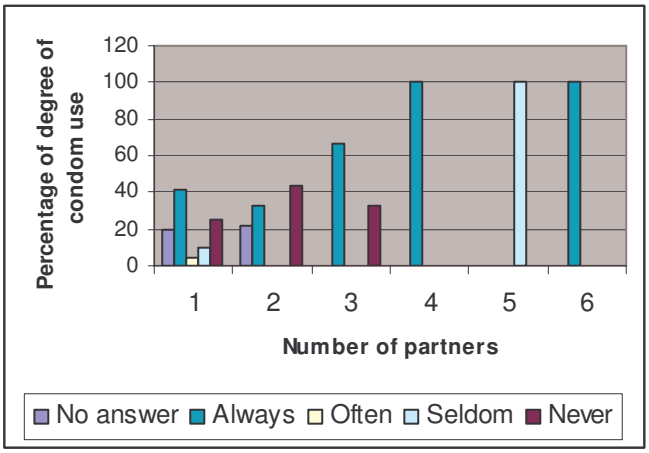

Figure 4.9 Condom use stratified with the number of partners

There are very few subjects with more than one partner (%), therefore the number of partners was converted into two categories, 1 partner and 2 or more partners and those with no partners were excluded from the analysis. Condom use was also converted into a binary variable (always and less use).

There are a number of factors such as age, sex, geographical area, education levels, occupation, and the number of partners that affect condom use in community trainees. In this study a logistic regression analysis using the SPSS statistical programme was done to assess if the above factors influenced condom use.

Logistic regression showed that sex (P value=0.4), occupation (P value =0.74), education (P value=0.32) and geographical area (P value=0.14) was shown to have no relationship with condom use. The model revealed a significant relationship between condom use and the number of partners (0.02) and age (P<0.001).

Although age had a significant relationship with condom use (P value<0.001), it also had a significant relationship with the number of partners (P value<0.001). Therefore the researcher believes that age may be a confounder or effect modifier. Therefore a further stratified analysis was done for age. Age was converted into a binary variable by dividing the study population into two categories: age less than or equal to the median (36years) and age greater than the median (36 years). The median was chosen since age was not normally distributed in the study population. The Mantel-Haenszel method was used to calculate the odds ratios after stratification for age.

Table 4.16 Relationship between condom use, age and number of partners

		Condom use	
		Less use	Always
Number of partners	2 or more partners	4	11
	1 partner	95	105

From table 4.16 the odds ratio is 0.40 (95% confidence interval 0.12-1.3). This means that the more partners a participant has, the less likely one will use a condom. However this is not significant (P value = 0.19) and the confidence intervals are wide.

Table 4.17 Relationship after stratification for younger age group (≤36 years).

		Condom use	
		Less use	Always
Number of partners	2 or more partners	3	9
	1 partner	39	65

From table 4.17 the odds ratio after stratification for the younger age group (<36 years) was 0.55. (95% confidence interval = 0.11-2.43, P value= 0.59)

Table 4.18 Relationship after stratification for older age group (>36 years).

		Condom use	
		Less use	Always
Number of partners	2 or more partners	1	2
	1 partner	56	40

From table 4.18 the odds ratio after stratification for the older age group (>36 years) is 0.37. (95% confidence interval= 0.01-5.28, P value= 0.78).

Thus the odds ratio changed from 0.4 to 0.55 in the younger age group and 0.35 in the older age group. Since the odds ratios in the two strata are different, age is thus an effect modifier and not a confounder. The effect is more pronounced in the younger age group.

However this interaction was not statistically significant (Woolf test of heterogeneity showed a P value= 0.29). This was probably due to wide confidence interval of the odds ratios.

From the analysis, it can be concluded that there is a relationship between the number of partners and condom use and age might be an effect modifier in this relationship although it is not statistically significant.

4.2.2.2.4 HIV Testing done by participant

Fifty four percent (144) of trainees had had an HIV test. Forty six percent (121) did not have a test done. The impact of various independent variables (sex, geographical areas, age, occupation, number of partners and educational status) on HIV testing was calculated using a chi-square test. This is reflected in Table 4.19

Table 4.19 Independent variables influence on HIV testing.

Independent variable	P value
Sex	0.66
Geographical area	0.73
Age	0.16
Occupation	0.17
Education	0.04
Number of partners	0.7

The chi-square test showed that there was no difference between geographical areas, sex, age, occupation and number of partners in terms of getting an HIV test. However the Chi square test showed that educational status had a significant association with getting an HIV test (P

value= 0.04). The higher the educational level the more likely the participant would have a HIV test.

4.2.2.2.5 Have you asked your partner to get a HIV test?

Fifty percent had asked their partner to go for an HIV test. Forty two percent did not ask their partners to go for an HIV test. Figure 4.11 and Table B4 in appendix B illustrates the urban rural difference.

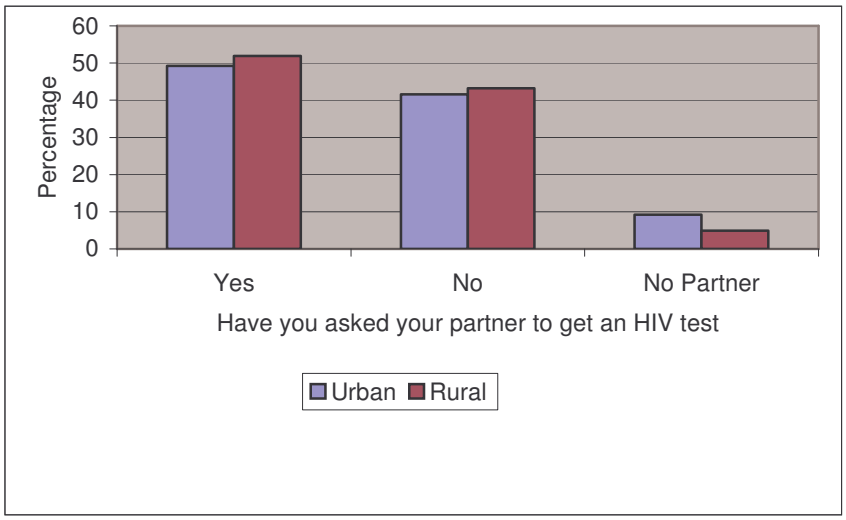

Figure 4.11 Rates of partners being requested to have an HIV test.

The chi square test showed that the place of residence (urban or rural) has no significant influence on the rate of a partner being requested to have an HIV test. (P value= 0.2).

4.2.3 Assessment of training

4.2.3.1 Participants were asked their opinion of the training.

The majority (94%) had positive views about the training. The following themes were predominant:

- **Improved knowledge**:
  - "Learnt a lot of things about HIV."
  - "Gives us knowledge on how to practice safe sex"
  - "Taught me to encourage HIV people, taught me how to help them."
  - " Helps me enlighten others on safe sex"

- **Positive change in attitudes, beliefs, and behaviour**:
  - "I am able to cope with people living with HIV/AIDS."
  - "Cleared myths that I was concerned about."
  - " It had an impact on many people because peoples behaviour changed for the better"
  - "Teaches people how to behave and respect people who are living with HIV/AIDS."

- **Increased the capacity of community trainees**:
  - "Helps me educate the community"
  - "It empowered us."
  - "We do not have jobs, but with the training we can be employed."
  - "I had a vision of talking to others about HIV/AIDS."

- **More needs to be done**

A few trainees (6%) thought that more should be done by Soul City in terms of the training:

- " Still need more training"
- " Should have it for a longer time"
- " The people in our provinces do not have resources to teach others"
- "We need more knowledge about other diseases."

Thus the overall impression of the training itself was very positive. A detailed table of the comments is in the appendix B, Table B5.

4.2.3.2 The Soul City materials

Ninety six percent (254) of community trainees received their Soul City material from the partner organisations. Four percent (11) did not receive any material from the partner organisations. Of all the materials distributed the booklets were received by 91% (240) of all trainees. Other materials such as the posters, charts, video cassettes were not distributed as widely.

Eighty one percent (215) obtained the material easily, but 19% (50) did not. There was more difficulty in the Northwest (33%) and Western Cape (31%) in receiving the materials. There was no difference between rural and urban areas. This is illustrated in figures 4.11 & 4.12)

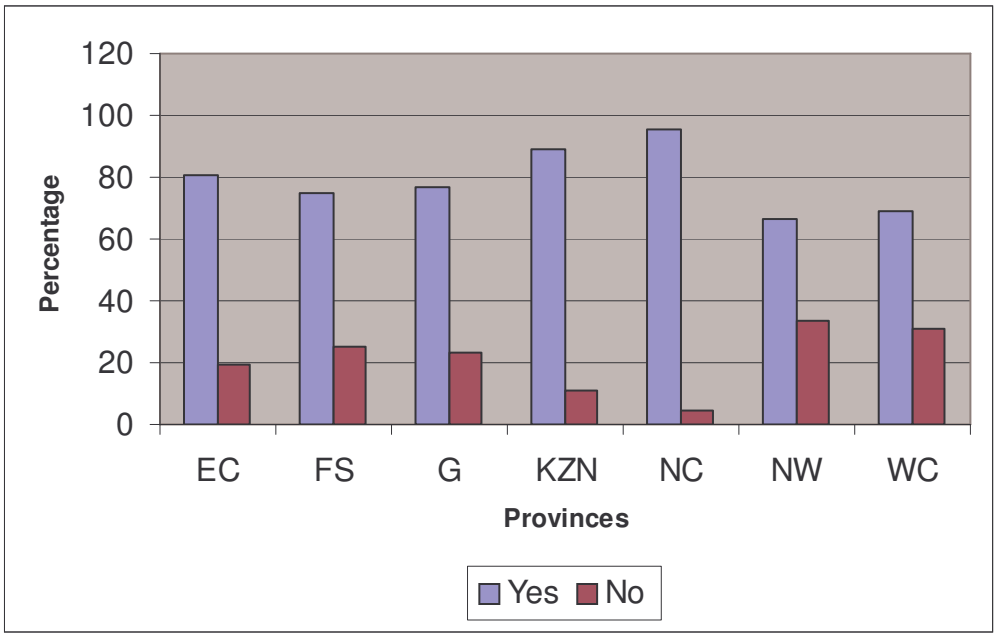

Figure 4.11 Ease of obtaining material

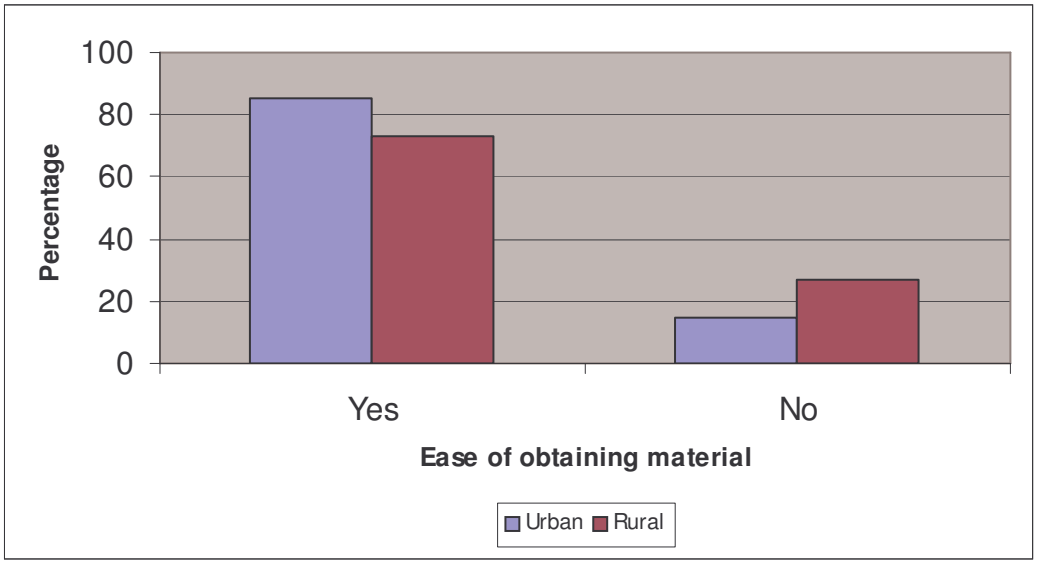

Figure 4.12 Urban vs. rural difference in obtaining material

The following table 4.20 reflects reasons why materials were not easily obtained:

Table 4.20 Reasons for not getting material easily. (n=265)

Explanations	**Number (%)**	**Area**
No material		
Have not received any material since the training.	**13 (4.9)**	**EC/G/KZN/NW**
No material was provided at the training	**4 (1.5)**	**EC/WC**
They do not supply everyone, they only choose particular groups	**3 (1.1)**	**EC/G**
Cannot get materials/ Limited Access		
Do not know where to get them	**11 (4.1)**	**EC/G/NC/WC**
Not easy to contact Soul City	**3 (1.1)**	**EC/G**
They (partner organisations) have limited material, so we just borrow and bring back	**3 (1.1)**	**EC/G/WC**
Sometimes they are not there/offices closed/ no access	**2 (0.8)**	**G**
No places nearby and Soul City don't come to our area	**2 (0.8)**	**EC/WC**
Many times they don't have what I ask for, no materials available	**2 (0.8)**	**EC/FS**
We get the material from Soul City Johannesburg but the distance is a problem/ sometimes we get the material late	**1 (0.4)**	**FS**
Sometimes the clinics do not have enough money for the material	**1 (0.4)**	**EC**
Suppliers do not make regular visits	**1 (0.4)**	**G**
We have to travel to Wynburg to get them/ travel to town to get them	**1 (0.4)**	**WC**
The only person who had access to the material was the leader	**1 (0.4)**	**G**

Booklets are not always available	**1 (0.4)**	**G**
We first have to give reports of people we have counseled before getting the material	**1 (0.4)**	**G**
Don't need the material		
There are other organisations who do the same thing	**1 (0.4)**	**EC**

Eighty nine percent of trainees (237) continued to use the material afterwards. A similar rate was noted across the provinces. There was no difference between the urban and rural areas.

4.2.3.3 Activities conducted by community trainees post training

Community trainees were then asked what they had done in relation to HIV/AIDS training. Again the response was very positive with the majority involved in some activity related to HIV/AIDS. These activities involved educating family, friends, communities, schools, clinics etc or had joined organisations to provide support groups, home based care or first aid. Others are distributing pamphlets or talking openly about personal experiences with HIV. Thus the training seems to have encouraged the community trainees to spread information and assist in community work regarding HIV. Table B6 in Appendix B has the complete list of activities conducted by community trainees

Table 4.21 illustrates that the majority of people trained or spoken to by the community trainees were family and friends- 78 and 75% respectively. This was followed by schools and religious groups.

A minority of community trainees (5%) have done absolutely nothing after the Soul City training.

Table 4.21 Percentages of the type of people taught by the community trainees (n=265)

	TOTAL	EC	FS	G	KZN	NC	NW	WC	URBAN	RURAL
Schools	60.4	73.4	62.5	63	16.2	72.7	66.7	38.5	64.3	51.9
Religious groups	44.2	53.2	87.5	43.8	27	36.4	33.3	7.7	42.7	46.9
Businesses	13.2	17.4	0	9.6	10.8	22.7	0	0	14.1	11.1
Friends	74.7	76.1	87.5	72.6	100	68.2	100	0	74.1	76.5
Family	78.1	76.1	100	72.6	100	72.7	66.7	61.5	76.8	81.5
The community	18.1	22.9	50	4.1	35.1	13.6	0	0	16.2	22.2
Clinics	3.8	0.9	0	9.6	2.7	4.5	0	0	3.8	3.7
No one presently	0.4	0	0	0	0	4.5	0	0	0	1.2

4.2.3.4 Personal impact of the training

Eighty six percent (86%) said that the training had some impact on them. It improved their knowledge, or resulted in a positive change in behaviour and also increased their capacity. The reasons given are noted in table 4.22.

Table 4.22 Impact of training on the trainees (n=265)

Explanations	Number (%)
Increased knowledge	
Have more information/ I now know what HIV is all about	85 (32.0)
Have learnt about life skills	16 (6.0)
There are lots of things I didn't understand and know	9 (3.4)
Made me aware how HIV can affect the whole area	1 (0.4)
Learnt more about counseling	1 (0.4)
Changed Attitude	
I learnt to accept a person that is HIV positive/ have changed my attitude towards AIDS people/ now know how to deal with HIV	45 (17.0)
Can talk openly about this sickness/ it gave me confidence to talk about this HIV/AIDS	41 (15.5)
Ability to help HIV people	23 (8.7)
Should not discriminate against people	7 (2.6)
Changed behaviour	
Helped me to be strong to have one partner	17 (6.4)
I was afraid to know my status but now I do	16 (6.0)
Encourage HIV people to have positive lives.	7 (2.6)
Speak to my friends and family about it.	4 (1.5)
Encouraged people to go for tests	3 (1.1)
I do house visits to help people that are infected	3 (1.1)
Coping skills improved	
My sister was HIV positive and my training helped me get through it/ my child is HIV positive	8 (3.0)
Other	
Best for school children	2 (0.7)
I am passing the message through the youth	2 (0.7)
Easy to understand	1 (0.4)

4.2.4 Recommendations made by the trainees

Trainees were asked how they felt the training could be improved. The following points were highlighted:

- Increase the training period (referring to workshops conducted by master trainers) or increase the amount of training (number of workshops).
- Soul City could provide more support in terms of funds, provision of certificates, food parcels.
- The content should include other information such ARV, pregnancy and HIV
- Improve access to material
- Train other groups of people not usually included in the training.

A list of all comments can be found in Table B7 in Appendix B.

5. DISCUSSION

5.1 Managers and Master trainers

5.1.1 Demographics

The majority of the managers and master trainers are Black (African), educated females. The study sample was comparable to the population sample as reflected in the results.

The race distribution of the master trainers shows that there are no Asian trainers and very few Coloured trainers (7%) in the sample. Soul City is targeting the poor and previously disadvantaged people in South Africa. However HIV affects all South Africans, with a national HIV prevalence rate of 21.5% according to UNICEF HIV/AIDS statistics.[34]
The Nelson Mandela Study 2002, shows that the HIV prevalence is 12.9% in Black South Africans, 6.2% in White South Africans, 6.1% in Coloured South Africans and 1.6% in Indian South Africans.[33] The data from the Nelson Mandela study does have limitations in its accuracy, however it shows that all communities are affected by HIV/ AIDS. Thus Soul City HIV training should target all these communities in order to positively influence the spread of the disease. Possibly the partner organisations within these communities need to develop strategies to target other race groups.

Nineteen (63%) of the sample are female**.** In sub Saharan Africa 57% of all the people with HIV are women and 76% of young people infected with HIV in Sub Saharan Africa are female.[20] Thus women are significantly affected by HIV and AIDS. However training women without as much focus on men might not have had the same impact as training both equally.

5.1.2 Training done by master trainers

The master trainers are training in all 9 provinces. The Eastern Cape has the majority of master trainers; however other rural and poorly resourced provinces such as the Limpopo (10%), North West (13%), Mapumalanga (13%) and Northern Province (17%) have fewer master trainers. Eighty percent of the master trainers train in formal urban settings, but only 57% (17) train in rural areas. This highlights poorer coverage of rural areas by the Training Programme. The lack of infrastructure in these areas, such as no electricity or no buildings for meetings, is a possible reason for limited rural training. Holding workshops in rural areas is also more expensive due to transport and accommodation expenses for trainers. This may decrease the number of workshops conducted. This is also reflected in the community trainees section of the study, where only 30% of community trainees conducted any form of training in rural areas. Unfortunately a limitation in the study was that community trainees were not asked if they lived in a rural or urban area.

HIV/AIDS has affected rural areas as well as urban areas. The Sector Network on Rural Development has shown that "Rural families are increasingly burdened by a considerable reduction of the family labour force, steadily increasing health care and funeral costs and severe food security risks" [25] because of HIV/AIDS. Thus it would be of great benefit to improve the rural coverage. The 2004 Report on Global AIDS Epidemic states that "Knowledge and information is the first line of defense against HIV."[1]

This study found that trainees from all sectors of the public are being recruited to the train the trainer workshops. This ranged from members of Non Governmental Organisations to

ordinary members of the community. The fact that a large number of community trainees are from other NGO's or the health and education sector would suggest that the capacity for training to continue at the next level exists and that people in fact go on to train others. However some master trainers and managers of the partner organisations complained that many of their community trainees did not have the capacity to conduct workshops either due to the lack of financial resources or the lack of time. Another problem that may be encountered in facilitating the continuation of training is that most of the community trainees (38.9%) are employed full time or have some form of employment (30.2%) and therefore may not have time to conduct workshops. However from the results of this study, this may not be a significant problem since the majority of community trainees (95%) appear to be facilitating the spread of information informally even if they are unable to conduct formal workshops. This is reflected in the comments seen in Table B9 in Appendix B. Only 14 (5%) of the community trainees did nothing. However the type message going out to the people in communities needs to be evaluated.

Not all organisations are conducting a follow up of the community trainees' activities. Many do not conduct a formal follow -up but only wait to see how many trainees actually come back for more material (passive follow up). The reason for not providing active follow-up was that there were not enough human and financial resources available. Follow up with community trainees will also help in evaluating the training that the partner organisations are providing.

5.1.3 Impact of the training at an organisational and personal level

100% of the participants stated that the Soul City training had an impact on the organisation. The training strengthened the organisation by increasing awareness of HIV, created other opportunities for the organisation and improved their credibility and exposure. The amount of training done by the organisations increased and enabled them to reach more people.

The majority stated that their knowledge (80%), attitudes (70%), training skills (80%) and presentation skills improved.

5.1.4 The management process

The master trainers and managers gave an average rating of 8 out of 10 for the Soul City administration. This on the scale 1 to 10, where 10 is the best, is a good rating of the partnership. Thus the majority felt very positive about their partnership with Soul City.

Unfortunately 14 (47%) out of the 30 respondents experienced some problem with the Soul City administration. All of the 14 experienced problems in relation to delayed payment of money to partner organisations by Soul City. Soul City had a standard procedure for paying partner organisations for the workshops conducted. This procedure of having invoices submitted before a payment was made was explained in the contract with the partner organisations. However a few partner organisations were not able to conform to this method and this resulted in delays. There were also administrative delays on the part of Soul City such as loosing information/ invoices .This resulted in workshops being cancelled or postponed.

Soul City is aware of this problem and it is currently being addressed with the appropriate organisations. The payment process is being streamlined and made easier for the partner organisations, so that there is no financial burden on the partner organisations. This should facilitate the continuation of the programme. Communication between Soul City and the partner organisations has also been improved. Thus if there is a problem it can be dealt with as soon as possible.

5.2Community Trainees

5.2.1 Demographics

The trainees were from all 9 provinces; however due to technical problems Limpopo and Mpumalanga were not included in this study. Most of the community trainees are from the Eastern Cape. This is also due to the fact that the majority of the master trainers are working in the Eastern Cape as well. As discussed earlier the urban rural distribution is also similar to the master trainers in that the majority of the training occurs in urban areas. The informal urban areas are also poorly covered. In the study done by Pettifor et al it was found that the HIV prevalence in youth living in urban informal settlements was 14.4%. This was higher than that found in rural (13%) and urban formal areas (9.8%).[30] The Nelson Mandela/HSRC Study of HIV/AIDS showed that in 2002 people between 15-49 years living in informal settlements have the highest prevalence (28.4%) compared to those in urban areas (15.8%) and rural areas (12.4%).[32] These statistics highlight the need for increasing coverage in

informal settlements. However community trainees from these areas might be accessing the train the trainer workshops within the urban areas, thus this might not be a significant problem. Unfortunately the study did not determine community level participation and thus it is unable to determine how many people in informal settlements access the Soul City Train the Trainer workshops.

Unfortunately it was not possible to get detailed demographic information about the study population. Thus the researcher was not able assess if the sample was truly representative of the population, however the sample was randomly selected from the study population and this may have resulted in a representative sample.

The sex distribution again is similar to the master trainers- i.e. the majority of the community trainees are female (85%). As stated earlier this might not be a problem, since educating women does enable the spread of information- as seen in this study. Mahatma Gandhi stated that “"If you educate a man you educate an individual but if you educate a woman you educate the entire family." [27] In places were women are not treated equally this might limit the impact of the training. [21] One of the respondents made a comment that the training should target more men. Thus training women without as much focus on men might not have the same impact as training both equally. Women form a vulnerable group in society – especially in rural, poverty stricken areas where they may be subjected to abuse and have very little empowerment. [21] Men should be targeted for training as well, as the responsibility to prevent infections, and for caring and supporting those infected should be shared by men and women equally. Unfortunately there is very little data or studies conducted regarding the attendance

of men to health related workshops or training. Generally most health related training sessions have focused on women. Although there is no formal research on why men are not attending these training sessions, from experience there are several reasons that could account for this. Men generally do not take on a supportive, caring roles and health related training is not seen as applying to them as well. Also men are usually looking for paid work and volunteer work (which is what Soul City training involves) will not appeal to them. Men alone may be less engaging due to more denial about HIV on their part.

5.2.2 Effectiveness of the training

The results show that the community trainees' knowledge and attitude towards HIV/AIDS is very good. Over 83% had 0 to 2 questions wrong and only 1% had over 4 questions incorrect. These results are very positive. An analysis of 250 North American education programmes by D. Kirby found that among sexually active young people, sex and AIDS education programs "can reduce sexual risk taking either by delaying sex, reducing the frequency of sex, decreasing the number of sexual partners, or increasing condom use." [1, 32] The 2004 report on the global AIDS epidemic also states that countries that have largely invested in HIV/AIDS education programmes have reduced the incidence of HIV. [1]

There was very little difference between males and females in the knowledge and attitude questions. Three questions showed a significant difference:

- "Having an HIV test is the only way to know if you have HIV/ AIDS"
- "There is a difference between HIV/AIDS"
- An HIV positive women cannot pass HIV to her baby"

The Nelson Mandela/HSRC Study also showed that males and females in their general population sample did not differ significantly in terms of knowledge and attitude towards HIV/AIDS.[33]

There was also very little difference between the age groups in this study, except for one question-"HIV positive people have the same rights as everyone else" (P value= 0.006). In the under 20 years age group- 16.7% did not know the answer and in the over 60 year age group, 10% disagreed with the above statement. The correct answer was achieved by > 98% of the 21-40 and 41-60 age groups.

The Nelson Mandela /HSRC study showed that in the general population sample that the oldest age group (grater or equal to 50 years) had the most incorrect answers. [33] Thus the community training should focus on those over 50 years and in the younger age groups.
The urban formal, urban informal and rural areas did not differ significantly in the number of correct answers, except in the following question:

- There is nothing you can do to prevent HIV and AIDS. (UF=93.4%, UI=73.7%, R=82.5%. P value =0.02). This question illustrates the degree of self efficacy which was greatest in the urban formal areas.

There was also no significant difference for knowledge and attitude in the different education levels. This is not surprising since most of the sample had secondary or tertiary education. The Nelson Mandela/HSRC study showed that higher education levels were associated with better knowledge and attitude.[33]

Overall, one question was not answered well by one third of trainees. These trainees thought that HIV positive women could not pass HIV to her baby. This is disturbing and should be rectified and highlighted by master trainers in the training conducted.

One of the other questions in this section stated that a caesarian section is the safest option for HIV positive women. The majority of participants thought this was true and it is stated in one of the workbooks. This statement, even though it may be true, should be discussed further with community trainees, since in the South African public health care system it is not practical in terms of financial and human resources for all HIV positive women to get Caesarian sections. The caesarian section rate in 2001 was 15.8% in the public sector.[27] Most of the deliveries are normal vaginal deliveries.

The results for knowledge and attitude are very encouraging; however they highlight gaps in the training that needs to be corrected. This will facilitate the spread of correct information about HIV/AIDS.

Behaviour of the trainees was also assessed. The results showed that 79.2% of community trainees were sexually active. The majority (92.9%) had only one partner. In this study the distribution of the number of partners was assessed for males and females and then compared. There was no significant difference between males and females in term of the number of partners.

Fifty three percent of community trainees always wore condoms and this was greater in rural areas compared to urban areas. The South African Health Systems Trust website reports that

in 2002 the condom distribution to females was 7.8 per 100 females; the condom distribution rate for males was 7.2 per male.[30] Thus condom distribution for males is significantly more than for the females. In this study it was found no significant difference between males (64.7%) and females (50.6%) in terms of always using condoms (P value=0.4). However the fact that there were too few males in the sample has probably affected the results. The Nelson Mandela / HSRC study showed that male youth had a 57.1% and female youth 46.1% level of condom use.[32] Thus the community trainees do have higher levels of condom use compared to the general population., but a comparison between male and female use of condoms cannot be effectively made due to the small number of males in the study.

Condom use is influenced by many factors. However it was found that the number of partners had a significant relationship with condom use (P value <0.02). Age had a significant relationship with condom use and number of partners. After stratification, age was found to be an effect modifier, but the relationship was not significant. Other factors that can affect condom use include attitudes, self efficacy, perceived social norm, alcohol consumption or exposure to interventions.

Fifty four percent of trainees had had a HIV test. Males and females were similar in terms of HIV self testing. In the national survey among 15-24 year olds by Pettifor et al it was reported that significantly more females reported having a HIV test compared to males (25% vs. 15%).[30] The above study also found significant differences between the age groups, the older youth reported having HIV tests more frequently than the younger groups. [29] In this study only educational status had a significant association with getting an HIV test (P

value=0.04). Thus the higher the level of education the more likely one is going to have an HIV test. This would be appropriate, since knowledge should result in more appropriate behaviour.

In summary it appears that the training was effective in influencing the behavior, knowledge and attitude towards HIV/AIDS. The knowledge and behaviour appear better than that of the general population. However this is a self selected group (that is these community trainees choose to go for HIV training), thus their behaviours, knowledge and attitude may have been better to start with.

5.2.3. Opinions regarding the training done by the master trainers:

The opinion of the community trainees was very positive. The training improved knowledge, lead to a positive change in attitudes, beliefs and behaviour and increased the capacity of the community trainees.

However there were a few problems related to obtaining the training material for further training by 19% of the community trainees especially in the Northwest and Western Cape. The reasons for this are reflected in Table 4.20. The material is free and thus this problem should not have occurred. The partner organisations need to be made aware that this problem has occurred since they order the books from a central distribution agent. Possibly not enough books were ordered for the number of participants and thus not all participants get the material. Of the community trainees that do get the material- 89% continue to use the material. This indicates the need to make sure that 100% of the community trainees get the

material. As mentioned earlier 95% of community trainees used the information they learned to train or educate family, friends and the community about HIV/AIDS. This facilitates the spread of information widely. The knowledge about HIV/AIDS is of good quality thus one can assume that the correct information is being communicated to others. Therefore one of the objectives of the training is being fulfilled.

5.2.4 Impact of the training on the community trainees.

Eighty six percent (86%) of the community trainees stated that the training had a positive impact mainly by improving their knowledge about HIV (32%). This is important in that if community trainees feel that the training is influencing their life they are more likely to spread the information.

There were a few suggestions by community trainees on how to improve the training received. Most notably the community trainees requested the training time to be increased. This was also highlighted by the master trainers who felt that 2 days was not enough to convey all the information necessary. Some Partner Organisations had increased the time period to 3 days. However this has an impact on the cost of each workshop and the number of workshops that can be eventually done.

Additional information on Anti retroviral therapy, pregnancy and HIV was lacking in their training. This need was highlighted by the knowledge section of the study-where one third of community trainees thought that a HIV positive woman could not pass HIV to her baby. The community trainees had expressed the need to get this information.

Overall the training appears to meet its objectives of training and supporting HIV/AIDS organisations, widely distributing its materials and developing skills throughout the country.

5.3 Limitations of the study

5.3.1 Sampling:

- In the community trainee sample, Limpopo and Mapumalanga were not included. This occurred because registration forms were not received in time. A problem with organisations sending reports timeously was noted. The record keeping at Soul City needs to be upgraded in order to facilitate a monitoring process.
- Full demographic data on the study population was not available and thus it is not known if the study sample is truly representative of the population. However the sample was randomly selected and it thus may be representative of the study population.
- Managers and master trainers were grouped together in order to maintain a degree of confidentiality. People from the organisation may have similar views and thus the variability within an organization may be minimal.

5.3.2 The participants:

- Unintentional bias may occur in the recruitment process since people who are HIV positive or have been affected by HIV or AIDS, may be more inclined to participate in training. This self selection might lead to bias in the sample compared to the general

population since these community trainees (CT) may have a higher knowledge and awareness of issues around HIV.

5.3.3 Type of survey:

- This study was conducted after an intervention and thus there were no control groups to compare the trainers and trainees with and there was no baseline to determine change from.. Thus it is difficult to assess accurately if the knowledge or behaviour was due to the training or was there before the training even took place. In future studies of this nature, the participants should be assessed before the training and then after completion of the training. This could become part of a continuous monitoring and evaluation system in Soul City.

5.3.4 Questionnaire:

- There were sensitive questions regarding sexual behaviour and HIV risk included in the community trainee questionnaire. Although the questionnaire was pre tested, participants may not have been totally honest. However the participants were given the option of refusing to answer.

5.3.5 Interviewing technique:

- Some participants that were interviewed face to face were more detailed in their responses, however the telephone interviews were of adequate quality. This might have affected the results of the study.

- Despite the training received by interviewers, there is still a possibility of interviewer bias. Participants may have given more positive responses either because of the interviewers' techniques.

5.3.6 Community level knowledge

- The study did not assess the communities. This would have been important in terms assessing the quality of the information delivered by the community trainees to members of the communities. Focused group interviews should be conducted in future evaluations.

5.3.7 Community trainees.

- When assessing the number of partners of each community trainee, it would have improved our understanding if marital status of the trainees were known. This was however not asked in the questionnaire.

5.3.8 Master trainers and managers.

- The fact that most managers and master trainers had positive responses may have been affected by their desire to get additional resources from Soul City. This may have affected the results and should be considered when making conclusions about the results.

6. RECOMMENDATIONS

6.1 Improving access to training materials.

People need to be informed especially at community trainee level of how to access the material. In this study 19% could not access the materials easily. The distribution of materials and ordering of materials by partner organisations must be improved. The materials produced by Soul City are free to the partner organisations and community trainees.

Master trainers need to be made aware that the training materials are available in other languages besides English. Several master trainers are still only using the English materials because their organisations were not ordering materials in the other languages. The accessibility of the materials will improve if the other languages can be accessed as well.

Videos are one of the many learning tools used in the training. The number of videos sent to organisations should be increased. Community trainees should be allowed access to these videos as well. This should increase the capacity of community trainees to reach illiterate people.

6.2 Training coverage should be increased in rural areas.

As seen in this study rural training is very limited and there is a need for the rural coverage to be increased. This might be accomplished by increasing the number of partner organisations that service these rural areas. This will decrease the load on the existing partner organisations that experience difficulty in getting to rural areas.

6.3 Administration

This process needs to be streamlined to facilitate the speedy transfer of funds to enable the workshops to continue and increase the number of workshops that can be done.

There should be discussions between each partner organisation and Soul City administration. Both parties need to find ways to submit and attend to claims for money timeously.

6.4 Improve communication between Soul City and partner organisations

There should be regular discussions between both parties to discuss problems, changes or improvements that may be needed for the programme. This sort of discussions will enhance the programme. Feedback to master trainers or the organisation after submitting reports should become part of the process.

Regular reports or news letters about new information or policies regarding HIV/AIDS should be disseminated to the organisations. This may not be the sole responsibility of Soul City, as there are many other sources of HIV/AIDS information. Soul City can guide the partner organisations and master trainers on where to access this information. The need for up to date information was clearly expressed by the master trainers. Thus this guidance could become part of the training process.

6.5 A regular monitoring and evaluation system

There needs to be regular monitoring of training to ensure quality control. This can also be used as a platform to provide feedback to organisations.

6.6 Follow up on community trainees

Organisations should develop some process to follow up on the majority of community trainees. It may be necessary to add the costs for the follow up process to the budget provided by Soul City. This will also enable monitoring of the spread of the training by the community trainees.

6.7 Involvement of other sectors in the training

In the study the gender difference was striking. In the master trainers and community trainee samples the majority are women. There has to be some focus on attracting men to participate in the workshops.

The white and Asian population groups would also benefit from this training. This would help disseminate HIV/AIDS information more widely.

7. CONCLUSION

One of the goals of the training programme was to train and support HIV/AIDS organisations at regional and local level. This study has shown it is doing just that. The cascade training is working in the Soul City Adult Education Programme. A large number of community trainees are being trained in all provinces and they are taking the messages out to the community. This should also enable the wide distribution of materials throughout the country. However the rural areas are not receiving adequate amounts of training. This poor rural distribution of training needs to be addressed.

The fact that the messages coming out are correct and the knowledge of all participants has improved and led to positive changes in behaviour and attitude is very encouraging. This suggests that the Soul City Adult Education Team is achieving their goal of supporting the development of high standard of HIV and AIDS Information and skills at all levels of the community in urban and to some extent in rural areas.

There are some difficulties with the programme namely the administrative problems but this should not limit the continuing success of the programme.

Key factors in a comprehensive HIV prevention programme are AIDS awareness and education and behaviour change programmes. [1] Thus in South Africa where resources of the majority of the population is limited due to poverty, Soul City is attempting to achieve the above by enabling and building up the capacity of these people, not only in HIV/ AIDS training but also in the development of life skills.

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9. APPENDIX

9.1 Appendix A – Managers and Master trainers

Table A1 Reasons why training needs to be improved.

1. Training time of 2 days is too short:

- "Training too short only 2 days"
- "Duration of training 2 days not enough. Have to roll out 7 booklets. Restricted by budget therefore can't extend the training."
- "2 day training not enough should be 3 days."
- "If need to develop skills in people need to give people more time to show if they develop skills. Therefore 3 days not sufficient, but other problem is money."
- "Major issue lack of time."
- "Time was the issue – 2 day workshop took time for people to get used to using comics. By the 2nd day have to cover the whole of the material. 3 days would have been better."
- "Allocation of time and repetitions- don't believe that you can go into a person's life and expect change- need repeated involvement."
- "Need more time. But then people can't afford to leave their home for more than 3 days."
- "Training is OK. But if can increase the number of days of training since some people had no basic knowledge need more time."

2. Always can improve:

- "One can always grow."
- "Can be improved since everyday learn more information and get experience from the community. But needs to be an ongoing thing with no big breaks in –between."

- "All training can be improved- what happens in sessions people disclose their status- can't deal with this therefore Soul City s now doing counseling.
- "Always room for improvement but what I don't know. I've been training for 17 years.
- "Need more
- "Need to do more workshops, and then facilitation skills will improve."
- "Not training all the time, need to do more workshops."

3. Access/ content of material:

- "People always ask for the video but can't give this."
- "Would like to give videos to people. If had a HIV positive person there – get more understanding"
- "Need to be more youth friendly especially the video. Only one video up till now not sufficient."
- "We need to rewrite the master trainer course. Because we train other people as master trainers but not all going out to train others. Can't always develop skills in a 3 day session"
- "Need to start incorporating new material from Soul City."
- "Material needs to be continuously updated. Need new information regularly."
- "Can be improved in counseling- not much in Soul city but done in other courses."
- "People know about this but need info on treatment and counseling. Some of the HIV/AIDS information e.g. in the video is outdated such as the pre and post test

counseling –the counselor gives wrong information. Does not cater for the issue of sexuality and homosexuals."

- "Manuals must be done in other languages"
- "Video used to have subtitles and questions- now not doing this. Need to do this again. It is important"

4. Certificates:

- "Soul City should provide certificates to master trainers. To acknowledge that the master training has actually been done. Since people ask."

5. Feedback:

- "Partners of Soul City need to get together for some refresher course and discuss experiences and how to improve training."

Reasons why no improvement is necessary.

- "The soul city time frame of 2 days has been changed to 3 days. We are also not following the workbooks as laid out. We have our own programme. We have a flexible training approach- adjust to the setting"
- "Satisfied with my training presently."
- "Training very good already- much better than the love life material, this is too explicit for some communities."

Table A2 Problems with training.

Problems mentioned:

1. Language

- Material only available in English- slight challenge but can still interpret and understand. Initially when ordered Xhosa booklets, it was not available and we ordered a large volume in English, so using this first.
- Once in North West language was a problem- Afrikaans town. It was difficult to communicate.
- Smoothly running. Would like the books in other languages. People don't come on time for the workshops, but ultimately it is a success.

2. Unable to train all.

- Once a busload from Shoshunguwe stopped the trainer and wanted her to train them but she couldn't since don't cover that area.
- Another problem is that since the training is free, people want to do the training. Therefore there is an overflow of people. But the problem is that not all may go onto train others or use the material. Therefore they have decided to do a preliminary assessment of trainees before they are selected.

3. Outdated material

- The video is outdated already. Therefore can't just give the video out and let the trainees (CT) use it since they may not be clued up with the material.

4. Trainee / venue related problems:

- In some venues there were no chairs or tables but we managed.
- Yes, transport problems. People don't always pitch up due to transport and money problems.
- The area is also male dominated therefore difficult to emphasise points since in denial, traditional. Need to change their mindset.
- Always take own equipment and not rely on the organisations you are training, since experienced a problem with this.
- No actual problems, except transport problems w hen go to very far away places.
- In our area too deep rural – need strong follow up. There are barriers- literacy, traveling. These aspects need to improve.

5. Other information needed

- The video used to have subtitles and questions. This is not done now; this is a problem because when it had a question after showing a bit of the video it allowed people to think. This is important and they need to do this again.
- Delays in getting the material if people want more.

6. Length of training

- The 2 day training is not enough. A week will be better.
- Time was an issue- 2 day workshop- took time for people to get used to using comics but by the 2nd day had to cover all the material- 3 days would have been better.
- The material should include more information on TB.

Listed below are comments made by those that had no problems with the training.

- No problems. Found it gratifying. People eager to learn. Their commitment keeps you motivated. Travelling costs and taxis sometimes a problem. 80% of people
- No problems with Soul city training
- No real problems. Except in some training workshops a few people (trainees) have disrupted the training. This was due to the reaction to what they were hearing and could not handle it emotionally. Something set off fairly sensitive things in them. And on one or two occasions these people came back the next day and apologised. So it wasn't due to the actual training or the master trainers.
- People are always satisfied.
- No problems. People very eager to learn. Even if people had info they still want more training and more information.
- No problems with the training. People seem to be happy. We don't use a rigid system. We adapt it to the people we train.
- No, trainers love the training – very well structured – people walk away with new ideas, even old trainers walk away elated. Get skills that are implemented immediately. People love it. Very powerful. Government gets no resources in clinics etc. therefore love Soul City material. Very successful approach. .
- None, since in training for 10 years now therefore no actual problems, except transport problems.

Table A3 Impact of the training on the organisation;

Strengthened the organisation:

- **"**The partnership is strengthened, despite only being mandated to do master training, the relationship has grown. Now we get other materials also from Soul City, not dealing with HIV/AIDS."
- "X learnt a number of things. Enriching. Some of the questions in the training sessions have helped in our own development. We have learnt a lot."
- **"**We never had training like this in PPASA. The Soul city training is an eye opener to us".
- **"**It has an incredible impact. It made us far more aware of HIV/AIDS. We would not have had this level of awareness professionally or on an individual level if not for Soul City."
- "Because of the methodology used by Soul City of funding partner organisations giving way material, CECD now is doing this. We have partner organisations in a similar way and do the training in a similar way."
- "More aware of HIV/AIDS and rely on the Soul City material to discuss relevant issues and people are now aware that material is available."
- "Also more at ease with the topic of HIV. People in the organisation are more relaxed and find it easier to discuss HIV/AIDS.
- Also use other Soul City material on domestic violence."
- "There is a lot we have to learn as an organisation. The communication skills within the organisation and with the community have improved since joining Soul City."

- "The training does not only impact on the people, but also has an impact on the peer educators and master trainers. The knowledge and lifestyle improved. The
- **"**When you look at the TV series and the material the people in the organisation become curious and ask for the workshops themselves. They volunteer to do more workshops."
- "Integrate the material in the home based care training. The use of the material is a great success."
- **"**It is useful for all of us to use. It is a gateway to train on HIV/AIDS. It is a good source of trustworthy info. Well researched, factual and at the right level for the audience. A number of people come to the training course and we also train our own staff with it. It is very useful."
- "Because of Soul City, FAMSA has had to look at how they are catering for HIV Positive staff. Now after the Soul city training they are developing policies for this."
- "Also it is easier for trainers to train since all the information is in front of them. Soul City is also easy to access and get info. Any organisation can start up HIV/AIDS Training using the Soul City material for the people in the community- especially the TV, radio and video shows make sense. The only problem is that it perpetuates the stigma that most people who get HIV are black since most of the characters are black."
- **"**Gained a lot of recognition. Opened opportunities that are get other contracts. Soul City popular and therefore partnership has made GAPSA more professional. Networking with other organisations due to Soul City**."**
- "Improves the quality of training, wonderful to give people access to it."

- "More work now, in HIV training."
- **"**Soul City resources and tools facilitate the transfer of information. This facilitates the work".
- **"**Transfer of skills. Before working with Soul City did not have a serious programme on HIV/AIDS, but now fully fledged programme and counselor training"
- "Gives my organisation credibility- widens my resources. "

<u>Able to reach more people</u>:

- **"**No financial benefit. As a training manager yes, peoples point of view yes. Since touches peoples lives. Gave us an opportunity to go to where people really needed us."
- "People know that they are in partnership with Soul City. Therefore come to X for help conducting workshops(material)."
- "Life orientation educators- if given an assignment –come here for information and resources. We feel happy since shows that the info is important for them. Also helps by marketing the organisation."
- **"**For the first time we had something to give to people. – knowledge about HIV/AIDS."
- "Improved in terms of the information. Material reaches all levels and made things easier for us."
- **"**It increases the demand for the training."
- "More information in an easy to use way in the Soul City material , than in the X manual and love life material (X &love life are in partnership). The Soul City

material can be used in different communities and the video is important. The organisation can train more easily."

- "People in the organisation can now help change the behaviour patterns in communities. They are thus keen to proceed with training and train others."
- "X is able to go into new areas due to Soul City."

Potential impact:

- "Would have a bigger impact if financial aspect sorted out. If this is sorted out can get more trainers and do more training and be more effective."
- "It has benefited me more than the organisation. Don't know what exact impact it has in the organisation. X is a TB NGO, only incorporating HIV in 2000 and the organisation is torn apart whether to incorporate it at all. Therefore I do most of the SC training myself."
- "Before we went out to do the workshops other staff members wanted the training and wanted to get the knowledge. The training done is only affecting a small percentage of people. Don't know how to change people's attitudes."
- "Provides a resource only, since trainers before Soul City and are aware of the different methods."

Table A4 Other opportunities for the organisation:

- "Drawn into other HIV initiatives and more contacts since association with Soul City. Exposure has increased."
- "Adds credibility to the organisation. Identify with it immediately."
- "Because it is a winning brand and because X is a preferred service provider for Soul City it has influenced and contributed to X – given us credibility.
- "Yes, because of association with Soul City, X has become a resource for other orgs in the Eastern Cape."
- "Different organisations approach us for Soul City training. We are now going to club Mykonos in September to train factory employees for the Soul City training."
- "We are now showered with requests for training maybe this is due to the Soul City training."
- "Difficult to know if the formal Soul City training has created opportunities. Somebody may award a tender due to the association with Soul City but not sure. I sense that the association has created opportunities."
- "We have only been with Soul City for 1 year therefore hadn't had any invitations that are due to Soul City training."
- "It is a very good thing to have a relationship with Soul City. To have it on your CV, people respect that."
- "Enriched my horizons. Invited to do training at a German Development service due to association with Soul City."
- "Yes, increased demand now because of the Soul City brand and training."

- "Prestige partnership for X. Difficult to measure but a lot of work now from the government."
- "In Free State X is the only organisation with partnerships with Soul City, this has given us more opportunities.**"**
- "Yes, now able to cover the very deep rural areas."
- "Improved the profile of GAPSA. If want a new contract and we put Soul City as a partner organisation- it gives some strength."
- "Get invites from other organisations outside the catchment area."
- "Recognition of being known to do HIV/AIDS training. Other organisations approach them to do training."
- "Has not opened up doors, but has strengthened links with NGO'S**."**
- "No. nothing tangible yet, but recognition improved."
- "Wherever we go, if we say we are going to use Soul City material it opens people to it."
- "Added some finances to X. Even though the money is used for Soul City training, it is still reflected in the annual report that additional funding is obtained."
- "Due to partnership we are now also training unions."
- "We are now able to work in other provinces as well."
- "X has also improved a lot since they also use the Soul City material in their own training. Where ever X goes people know of the association with Soul City and ask for Soul City material. Even if X go to a place or training as X, people show more interest in them if they know they are associated with Soul City."
- "Exposure improved**.** Now able to give knowledge to people who need it."

- "Other organisations now ask for the Soul city course. This has increased the opportunities."

Table A5 Further support from Soul City:

1. Increase the amount of work doing with Soul City.

- "We would like to extend the partnerships. To do larger project since we have the capacity and the knowledge and a good training model. Can add value to Soul City. Therefore can be involved in a large scale with Soul City."
- "Would like to be involved in other projects with Soul City**."**
- "SC could make more use of X. They underestimate the service provider's contribution to SC. We can give more."
- "Can do other training for SC. Also assist them with manuals."
- "Would like to do more training for Soul City, does not only have to be this."

2. Require more information.

- "Provide any updated information. And give us more videos- only have one and we have 6 trainers going out to train. If they can vary the videos also."
- "More counseling info and help with this."
- "If possible some in-service training by Soul City. To come regularly to Soul City like twice a year for updates."
- "Counseling information needed."

- "Only big concern is the rollout of ARV, but now can fill this gap – going for training."
- "If not clear about some questions from community want to call Soul city for more information."
- "Counseling skills were needed a year ago- told them. Now doing it."
- "Nice to give out a newsletter with updates. Need up to date information on HIV/AIDS for example the controversy around nevirapine. Also the book given to journalists on background information was very useful. Should get more like that."
- "Need for support for implementation of counseling. Need some guidelines of how to put what I have learnt into practice. That needs a framework of how to make people counselors."
- "There is a huge demand for care and counseling courses, therefore should offer more courses for more master trainers to do this."

3. Communication/ more discussions.

- "Working closer with them, guidance in some work, debate ways and means of behaviour change, what is not working well."
- "Besides the actual training important to come back physically and discuss the challenges and strengths of the Soul City training. Once a year Soul City should call all its master trainers and have a 2-3 day feedback session."
- "Relaxed on the monitoring side. Onus on them to ask."
- "Visit us more often."

- "Would like them to make contact with us more frequently to see how everything is going. This will be encouraging."
- "Visit us at least once during the course of training."
- "Would like to see them more often, otherwise the material is good."
- "If they can make a point of coming and visiting us to see the training. And also to see what impact the training is having. Need to come down to the level of the people in the training and see how these people feel."

4. Establishing more partners in area.

- "We need more partners in this area (Northern cape). We work in Kimberly, but the other areas are so far that it is very taxing to get there, for example top go to Springbok need to travel for a whole day. We are over extending ourselves. We are in a position to refer to other agencies. We did this once in the Siyanda district."

5. Accreditation

- "Facilitating a process of accreditation for this course. Then they can certify people."

6. Increase visibility.

- **"**Instead of more money going into films, it should go into promotional material like Soul City t-shirts etc. Love life more visible and more people know it. Also if we had some visible thing like a cap, t shirt or jacket with the Soul City and X emblem to show the partnership with Soul City. Since sometimes people say that you can obtain

these books for free so you need other forms of confirmation of the association with Soul City."

- "Coming to training sessions- will add a lot of value. Trainees would like to see someone from Soul City since we are in partnership."
- "T-shirts –people want this, but don't always get them, also the Soul city books."

7. Incentives.

- "It would be nice if we were given incentives by Soul City such as money."

8. No support needed.

- "No support needed, training for 17 years."
- "None. Soul City is doing enough. Their services are still very good. In the future will use Soul City a lot".

9. Support the trainees.

- "Support the trainers- follow up or give them advice or help with resources. People trained in some areas but because they don't have resources/empowerment to continue the training nothing gets done. Capacity out there is limited. Therefore have to go out again to some areas and do training for the whole community instead of the trainees doing it."
- "Make sure and help other trainees set up training itself- monetary help."
- "More support for the trainees. Because after the training so many people are motivated to do something in the community. Would like Soul City to go and see some of the trainees and see what they are doing. This will have a great impact."

10. More videos.

- "Get more videos-so can give it to people. People like it and relate to the characters."
- "And give us more videos- only have one and we have 6 trainers going out to train. If they can vary the videos also."

9.2 Appendix B - Community Trainees

Table B1 Employment status

Employment Status	Percentage	Number
Student	4.9	13
Unemployed-not looking for work	1.5	4
Unemployed-looking for work	24.5	65
Informal sector-not looking for permanent work	0	0
Informal sector-looking for permanent work	0	0
Pensioner	2.3	6
Housewife, not looking for work	0	0
Housewife, looking for work	0.4	1
Self-employed-full time	1.9	5
Self-employed- part time	2.3	6
Employed part time	7.2	19
Employed full time	38.9	103
HIV Volunteer	16.2	43

Table B2 Knowledge / Attitude/ Risk/ Behaviour:

	Statements	Agree		Disagree		I don't' know	
		%	No.	%	No.	%	No.
a.	Having an HIV test is the only way to know if you have HIV or AIDS.	96.6	256	3.4	9	0	0
b.	There is nothing you can do to prevent getting HIV and AIDS.	11.3	30	88.7	235	0	0
c	Once HIV is in your body, it never goes away.	94.7	251	5.3	14	0	0
e	There is a difference between HIV and AIDS.	95.8	254	4.2	11	0	0
f	You can tell from looking at a person that they have HIV.	12.8	34	87.2	231	0	0
g	People with HIV/AIDS should be kept away from other people.	3.4	9	96.6	256	0	0
h	It is safe to touch and hold someone who has HIV/AIDS.	93.6	248	6.4	17	0	0
i	An HIV positive woman cannot pass HIV to her baby.	31.3	83	68.3	181	0.4	1
j	It is safer for a woman who is HIV positive to have a c- section (operation) rather than a normal birth.	68.3	181	30.2	80	1.5	4
k	There are no medicines to cure HIV.	88.3	234	11.7	31	0	0
l	Antiretroviral drugs slow the progression of AIDS but don't cure it.	97.7	259	1.9	5	0.4	1
m	HIV positive people have the same rights as everyone else?	98.5	261	1.5	4	0	0
n	People living with HIV & AIDS need support from the community.	100	265	0	0	0	0
o	It is good to talk openly about being HIV positive.	99.2	263	0.4	1	0.4	1
p	HIV/AIDS affects everyone in the community in some way.	94	249	6	16	0	0

Table B3 Sexual Activity across provinces

PROVINCES	Yes		No	
	%	No.	%	No.
EC	84%	92	16%	17
FS	50%	4	50%	4
G	75%	55	25%	18
KZN	78%	29	22%	8
NC	82%	8	18%	4
NW	67%	2	33%	1
WC	77%	10	23%	3

Table B4 Urban vs. rural distribution of community trainees requesting their partners get HIV tests

	Urban		Rural		Total
	%	No.	%	No.	
Yes	49.2%	91	51.9%	41	132
No	41.6%	77	43.2%	35	112
No Partner	9.2%	17	4.9%	4	21
	100%	**185**	**100%**	**80**	**265**

Table B5 Participants opinion of the training received:

	%	No.
Learnt a lot of things about HIV/ have more information about Aids	**50.2**	**133**
It was good/it was great/Excellent	**26**	**69**
I am able to cope with people living with HIV/ HIV positive person is always my friend	**9.8**	**26**
Taught me to encourage HIV affected people/ taught me how to help people with HIV/ I now know how to look after them.	**7.5**	**20**
Gives us knowledge on how to practice safe sex/how to prevent getting affected/ taught me that I must always use a condom/gloves	**6**	**16**
It has changed my beliefs about HIV/ AIDS/ cleared myths that I was concerned about	**4.9**	**13**
Teaches people how to behave and respect people who are living with HIV/AIDS	**4.9**	**13**
Educational/ Very interesting	**4.5**	**12**
It was fruitful/ it was a great help to me/it was helpful	**4.5**	**12**
Still need more training/ we need more information about AIDS	**3**	**8**
Enlightened us to talk openly about our status	**2.6**	**7**
I had a vision of talking to others about HIV/AIDS/ helps me to educate the community/ taught me top teach others	**2.6**	**7**
Easy to understand	**1.9**	**5**
Should have it more often/ Should have it for a longer time	**1.9**	**5**
It has had an impact on many people because people's behaviour has changed for the better	**1.1**	**3**
It empowered me/ it empowered us	**1.1**	**3**
The training was challenging	**1.1**	**3**
The training was pointed at youngsters	**0.8**	**2**
The video that they promised us we didn't get	**0.4**	**1**
We do not have jobs, but with the training we can be employed	**0.4**	**1**
The people in our provinces do not have the resources to teach others	**0.4**	**1**
It was good because it empowered the schools and have a special period for training at schools	**0.4**	**1**
Helps me to enlighten others on safe sex	**0.4**	**1**
They should provide us with cassettes so that it will be easy to conduct the workshops	**0.4**	**1**
I think everyone should get training	**0.4**	**1**
It was good because they were speaking our language	**0.4**	**1**
I now know the difference between HIV and AIDS	**0.4**	**1**
I learnt what symptoms come with HIV	**0.4**	**1**
We need more knowledge about other diseases	**0.4**	**1**
Taught me a lot about abuse	**0.4**	**1**

Table B6 Activities done in relation to HIV/AIDS Training

Activities	%	No
Tried to educate members of the community	22.6	60
Tried to educate my learners at school	10.9	29
Tried to educate the youth of the church/ Advise the youth about AIDS/ Teach Sunday school children about AIDS	9.8	26
Educate my friends	9.8	26
Help organise workshops/ hold workshops	8.3	22
I talk to people who have HIV/AIDS/ I counsel the HIV positive in church	7.2	19
I am now training people to do community work like home-based care	6	16
Involved in support groups	5.7	15
Do house visits- bath people with AIDS/ Help the sick by visiting them	4.5	12
We are educating people about HIV/AIDS in clinics/ AIDS awareness in clinics	4.2	11
I am an HIV/AIDS consultant	4.2	11
Giving food parcels to the infected person/ do charity collections	3	8
I am a training volunteer for other organisations	2.6	7
Educate my family	2.3	6
I have done home-based care/ First aid and nursing	2.3	6
Helped many people who are infected to come out and speak/ inform people who live with the disease	1.9	5
Volunteer at the mobile clinic	1.9	5
Taught people to take the right diet after they know their status	1.9	5
Discuss with the parents at the day care centre	1.5	4
I am a training volunteer for church groups	1.5	4
We encourage people to go for an HIV test	1.1	3
Spread the booklets and pamphlets to read about HIV	1.1	3
Encourage people to watch Soul City	0.8	2
Spoke about it at my brothers funeral/ brother was affected by AIDS	0.8	2
Motivate people about the disease	0.8	2
Learnt to respect other peoples privacy	0.8	2
Involved with the children who are HIV positive in my community/ involved with orphanage children	0.8	2
Volunteering	0.4	1
Encourage youth to use condoms	0.4	1
Give all the time I can to the sick in my community	0.4	1
I joined the project UBUNTU CARE HOSPICE where we visit people who are HIV positive	0.4	1
I support my colleagues who are HIV positive	0.4	1
Involved in HIV programme	0.4	1
Nothing	5.3	14

Table B7 Community Trainees opinions of what improvements are needed in the training. (Recommendations)

Opinions	%	No:
Increase the training period/ Increase the amount of training		
They should have longer training/ training should last at least 3 days/ should last a month	9.4	25
More training needed	9.1	24
Training should be held every 2 months	3.8	10
They should have more trainers	1.1	3
If it can be done again and people have access to it then I think it will help	0.4	1
Have more workshops	1.9	5
The training should be free so that every one can attend	0.4	1
It should be done in all communities	6	16
The facilitator did not know much on pregnant mothers, at least improve on that.	1.9	5
They should have more trainers	1.1	3
Have more black trainers	0.4	1
They should send us active representatives	0.4	1
Suggestions regarding the material content or access		
They should have enough material	7.5	20
Could have been done in another language	2.3	6
The material should be distributed house to house after every training	1.1	3
There should be additional information on grants for people that are already infected	1.1	3
They should train us about antiretrovirals	1.5	4
They should introduce someone with AIDS	0.8	2
Should have more activities so that teenagers don't get bored	0.8	2
Provide more booklets	0.8	2
Have more information	0.8	2
They should inform us on what food people should eat	0.4	1
Make women aware of female condoms	0.4	1
Have more practicals	0.4	1
More counseling especially on couples	0.4	1
Tell people about the governments policy	0.4	1
They should add new things on the video	0.4	1
Train other people		
Involve the youth in training	2.3	6
They must go directly to schools	1.9	5
Invite older people	0.8	2
Need to invite people from the business sector	0.4	1
Go to the ZCC Church because you are not allowed to use protection	0.4	1

Invite males to the training	0.4	1
Provide support		
Offer funds to keep going	1.5	4
Provide transport for people that live far away	1.1	3
They should give certificates that indicate that we have received training	0.8	2
Give us gloves/bandages to help a child that is wounded	0.4	1
Give out food parcels	0.4	1
Help people to disclose their status	0.4	1
Doing a good job		
They are doing a good job/ Keep up the good work	41.1	109

9.3Appendix C

Information sheets, Consent forms and Questionnaires.

Evaluation of HIV/AIDS Training

RESEARCH PARTICIPANT INFORMATION SHEET

Introduction:
My name is _____. I am a researcher from the University of Witwatersrand. We are trying to find out about training related to HIV/AIDS.

What the Research Project Aims to Do:
The objective of this study is to evaluate the impact of the training and to determine what improvements can be made to the training programme.

If you are willing to participate in the study, we would like you to fill in the attached questionnaire.

Consent and confidentiality:
To be able to participate you have to give me written consent. I will give you a form to read, or I will read it out to you, and you have to sign it. You should only give consent if you are happy to be interviewed and fill in the questionnaire. It is entirely voluntary. If you do not want to participate, it is totally within your rights, and nothing will happen.

You will not be identified in the study. You will remain anonymous.
As soon as the study is completed the consent forms will be kept separately in a locked cupboard in my office. The information about what you said will be kept separately.

Thus no names will be mentioned unless permission is given by the individual and the organisation.

Report:
A draft report will be given to all partner organisations involved so that they can give further input.

Questions:
If you have any questions, please feel free to ask me.
If you require any further information please contact me (contact details below).

Thank you for your cooperation.

Dr N. Naicker.
School of Public Health
University of the Witwatersrand
Cell no: 072 117 3408
Email: naickern@hsc.pg.wits.ac.za

Evaluation of Soul City Adult Education Training

CONSENT FORM
Trainers and Community Trainees

I have read the project information sheet/or had it read to me, and I understand what it says.

I understand that the interview/ questionnaire is strictly confidential.

I understand that I do not have to do this interview, and that it is entirely voluntary.

I understand that during the interview I have the right not to answer any questions, and may finish the interview at any time.

I understand that the information that I give will be treated in the strictest confidence.

Interviewee's signature:

Date: _____

Evaluation of the Soul City Adult Education Training

Questionnaire
Master trainers and Managers

Questionnaire number

Interviewer name

Name of organisation linked to:

DEMOGRAPHICS:

1. Province

2. Type of area where the respondent conducts his/her training.

Metropolitan Formal	1
Metropolitan Informal	2
Rural Village	3
Rural on Farm	4
Rural Scattered	5

3. Sex of respondent

Male	1
Female	2

4. What is your age in completed years?

Years

5. What language do you speak at home most of the time?

English	1
Afrikaans	2
Zulu	3
South Sotho	4
Setswana	5
Xhosa	6
Pedi / North Sotho	7
Venda	8
Tsonga	9
Seswati	10
Ndebele	11
Other: ……	

6. RACE

African	1
Coloured	2
Asian	3
White	4

7. What is your highest level of education?

NONE	01
SOME PRIMARY	02
PRIMARY COMPLETED	03
SOME SECONDARY	04
SECONDARY COMPLETED	05
TERTIARY	06
OTHER (SPECIFY) …… ……	07

8. What is the length of time you have worked at the organisation to which you belong? | | |

7. What is your position in the organization? [If the respondent carries out more than one task ask which task takes up most time. Remember to allow for one answer only]

Trainer / facilitator	1
Peer Educator	2
Counsellor	3
Human resource person	4
Resource centre person / Librarian	5
Training / Outreach Co-ordinator or manager	6
Director	7
Other: (specify)	8

TRAINING:

1. How many workshops/training that deals with HIV/AIDS did you conduct last year (2003)? | | |

2. What were the topics of these workshops?

   _____
   _____
   _____
   _____

3. Where does the master training conducted by the master trainers take place?

   _____
   _____
   _____

4. How do you recruit trainees for the master training?

   _____
   _____
   _____

5. Please indicate the type of people you train in the master training courses.

Other Non governmental organisations	1
Teachers at schools	2
Counsellors	3
Business sector	4
Nurses	5
Other allied health care workers	6
Religious groups	7
Other: (specify)	8

6. Do you follow –up on the trainees' activities?

YES	1
NO	2

(ie. Are they themselves training others in the community etc)

Please explain your answer: _____
_____
_____
_____

7. In how many training sessions did you use Soul City material? | | |

8. What other material do you use in your training?

_____
_____
_____
_____

9. Do you provide the trainees with Soul City material to take home?

YES	1
NO	2

10. How did you find using the Soul City training material?

_____
_____
_____
_____
_____

11. What resources do you provide for the trainees after the training?

_____
_____
_____
_____

12. Do you think your training can be improved in any way?

YES	1
NO	2

13. If yes, please explain. _____

_____
_____
_____

14. Have you experienced any problems with the training?

YES	1
NO	2

15. If yes, please explain. _____

_____

_____

_____

IMPACT OF THE TRAINING:

16. Does Soul City training have an impact on the organisation?

YES	1
NO	2

If yes, please explain. _____

_____

_____

_____

If no, please explain._____

_____

_____

17. Has the partnership with Soul City and the Soul City training made a difference in the amount of training that you do?

YES	1
NO	2

If yes, please explain. _____

_____

_____

_____

18. Do you think that the Soul City Training changed your-?

	YES	**NO**	**I DON'T KNOW**
Knowledge on HIV/AIDS			
Attitudes regarding HIV/AIDS			
Training skills			
Presentation skills			
Other : specify …… ……..			

If the answer is no for any item, please explain. _____

_____

_____

19. Has your organisation had any other opportunities because of the Soul city training?

YES	1
NO	2

20. Is there anything else you would like to say about the Soul City Training?

_____
_____
_____
_____

ADMINISTRATION:

21. Overall how would you rate the partnership with Soul City on a scale of 1-10 where 10 is the best and 1 is the worst.

22. In the partnership with Soul City did you experience any administrative problems?

YES	1
NO	2

If yes, please explain. _____
_____
_____
_____
_____

23. Have there been any problems in relation to any of the following?

	YES	***NO***
Money		
Supervision		
Report writing		
Other : please specify: …….. ……..		

If yes to any of the above, please explain: _____
_____
_____
_____

YES	1

24. Is there any aspects of the administration that are good?

NO	2

Please explain: _____
_____
_____

25. Is there any further support that Soul City can give you?

YES	1
NO	2

Please explain. _____
_____
_____
_____

26. How do you monitor and evaluate the training done by the master trainers?

_____
_____
_____
_____
_____

THANK YOU.

Evaluation of Soul City Adult Education Training

Questionnaire
Community Trainees

Questionnaire number

Interviewer name

Name of organisation linked to:

DEMOGRAPHICS:

1. Province

2. Type of area where the respondent conducts the training?

Metropolitan Formal	1
Metropolitan Informal	2
Rural Village	3
Rural on Farm	4
Rural Scattered	5

3. Sex of respondent

Male	1
Female	2

4. What is your age in completed years?

5. What is your current employment status (which of the following best describes your present work situation)?

Student/scholar	01
Unemployed, not looking for work	02
Unemployed, looking for work	03
Work in informal sector, not looking for permanent work	04
Work in informal sector, looking for permanent work	05
Pensioner (sick/disabled, etc.)	06
Housewife, not working at all, not looking for work	07
Housewife, looking for work	08
Self-employed - full time	09
Self-employed - part time	10
Employed part time (if none of the above)	11
Employed full time	12
Other (specify) …… ……	13

6. What is your highest educational qualification?

None	01
Some primary	02
Primary completed	03
Some secondary	04
Secondary completed	05
Tertiary	06
Other (specify) ……	07

7. What language do you speak at home most of the time?

English	1
Afrikaans	2
Zulu	3
South Sotho	4
Setswana	5
Xhosa	6
Pedi / North Sotho	7
Venda	8
Tsonga	9
Seswati	10
Ndebele	11
Other: …….	

8. RACE

African	1
Coloured	2
Asian	3
White	4

KNOWLEDGE / ATTITUDE / RISK/ BEHAVIOUR:

1. State whether you Agree/ Disagree/ I Don't Know, regarding the following statements?

	Statements	**Agree**	**Disagree**	**I don't' know**
a.	Having an HIV test is the only way to know if you have HIV or AIDS.	1	2	3
b.	There is nothing you can do to prevent getting HIV and AIDS.	1	2	3
c	Once HIV is in your body, it never goes away.	1	2	3
d	The proper use of the condom is the only method that protects you against pregnancy, STD's and HIV.	1	2	3
e	There is a difference between HIV and AIDS.	1	2	3
f	You can tell from looking at a person that they have HIV.	1	2	3
g	People with HIV/AIDS should be kept away from other people.	1	2	3
h	It is safe to touch and hold someone who has HIV/AIDS.	1	2	3
i	An HIV positive woman cannot pass HIV to her baby.	1	2	3
j	It is safer for a women who is HIV positive to have an c- section (operation) rather than a normal birth.	1	2	3
k	There are no medicines to cure HIV.	1	2	3
l	Antiretroviral drugs slow the progression of AIDS but don't cure it.	1	2	3
m	HIV positive people have the same rights as everyone else?	1	2	3
n	People living with HIV & AIDS need support from the community.	1	2	3
o	It is good to talk openly about being HIV positive.	1	2	3
p	HIV/AIDS affects everyone in the community in some way.	1	2	3

2. Are you currently sexually active?

YES	1
NO	2

3. How many sexual partners have you had over the last 12 months? ☐

4. When do you use a condom?

Always	1
Often	2
Seldom	3
Never	4
Not Sexually Active	5

5. Have you ever been tested for HIV?

YES	1
NO	2

6. Have you asked your partner to go for a test?

YES	1
NO	2

TRAINING:

1. Where did you receive HIV/AIDS training? _____

   _____

2. Which organisation provided the training? _____

3. What did you think of the training? _____

   _____

   _____

   _____

4. What have you done in relation to HIV/AIDS training since the workshop?

   _____

   _____

   _____

   _____

5. Was Soul City material used in the HIV/AIDS training that you received?

YES	1
NO	2

If yes which material did you receive?_____
_____

6. Did you use Soul City material after the training?

YES	1
NO	2

7. If yes, how often do you use Soul City Material?

Never	1
Seldom	2
Frequently	3
Always	4

8. From where do you get the Soul City Material? _____
_____

9. Was it easy to get?

YES	1
NO	2

10. If no, please explain. _____
_____
_____
_____

11. Who do you train or speak to about HIV/AIDS?

Schools	1
Religious groups	2
Businesses	3
Friends	4
Family	5
Other : specify ……..	6

12. Has attending the Soul City training impacted on you personally?

YES	1
NO	2

13. If yes, please explain. _____

_____
_____
_____
_____

RECOMMENDATIONS:

1. How do you feel that the training, which you received, can be improved?

_____
_____
_____
_____

2. Is there anything that you would like to say to Soul City?

_____
_____
_____
_____
_____

Thank you.